FY12 Performance Plan

December 2012

?

Department of Health and Human Services

Uma S. Ahluwalia, Director

Overview

Contribution to Montgomery County Results

The Department of Health and Human Services (DHHS)' Headline Measures are ordered in the plan according to their primary contribution to Montgomery County Results.

DHHS At-A-Glance

DHHS ensures delivery of a full array of services to address the somatic and behavioral health, economic and housing security, and other health and human services needs of County residents. DHHS directs, manages, administers, funds and delivers critical supports for the most vulnerable residents. Services provided also include case management and advocacy services, protective services for vulnerable children and adults, and prevention services.

The Department strives to provide services that:

- Build on the strengths of our customers and the community
- Are community-based
- Are accessible
- Are culturally competent
- Are responsive to changing needs of our community
- Are provided in collaboration with our community partners.

What DHHS Does and for Whom	How Much - FY 12 Budget & Work Years (WY)
Overall The mission of the Department of Health and Human Services (DHHS) is to promote and ensure the health and safety of the residents of Montgomery County and to build individual and family strength and self-sufficiency.	**$242.1 million** **1485.7**
Aging and Disability Services (ADS) The mission of ADS is to affirm the dignity and value of seniors, persons with disabilities, and their families by offering a wide range of information, home and community-based support services, protections, and opportunities which promote choice, independence, and inclusion.	**$36.6 million** **158.7 WYs**
Behavioral Health and Crisis Services (BHCS) The mission of BHCS is to foster the development of a comprehensive system of services to assist children, youth, adults, and families in crisis or behavioral health needs.	**$37.2 million** **194.5 WYs**
Children, Youth and Family Services (CYFS) The mission of CYFS is to promote opportunities for children to grow up healthy, and ready for school, and for families to be self-sufficient.	**$58.0 million** **417.8 WYs**
Public Health Services (PHS) The mission of PHS is to protect and promote the health and safety of County residents.	**$68.4 million** **540.3 WYs**

What DHHS Does and for Whom	How Much – FY 12 Budget & Work Years (WY)
Special Needs Housing (SNH) The mission of SNH is to provide oversight and leadership to the County's efforts to develop new and innovative housing models to serve special needs and homeless populations and maintain housing stability for vulnerable households.	**$17.3 million** **56.3 WYs**
Administration and Support (AS) The mission of AS is to provide overall leadership, administration and direction to the Department, while providing an efficient system of support services to assure effective management and delivery of services.	**$24.5 million** **118.1 WYs**

1. Team-based Case Management

Basic Facts

- Cross-systems team-based case management of individual or family cases that receive multiple services:
  - Offers a more coordinated, systematic and comprehensive approach to meeting the customer's needs.
  - Creates efficiencies through communication and coordinated service delivery for customers.
  - Leads to improved outcomes for customers: risk mitigation, greater independence, improved health, better access to services and successful case closure.
- Based solely on Client Record System (CRS) data, more than 28,000 unique individuals received more than one service (see table below).
- CRS data represent active clients that had a documented encounter with DHHS. The universe of active clients is higher for two reasons:
  - Clients who are active but did not have a documented encounter in FY11 are not reflected in the data
  - There are several other mandatory state or federal databases of DHHS clients (although CRS is the largest). Some individuals in other databases are not in CRS.
- The actual number of individuals receiving multiple services is unknown due to the lack of interoperable databases.

Client Record System Data of Active Cases Receiving Multiple Services

Number of Services	Number of Clients				
	FY 07	FY08	FY09	FY10	FY11
2	9,485	11,412	13,011	12,653	14,658
3	5,362	6,298	6,905	6,283	6,911
4	3,078	3,668	3,739	3,152	3,656
5	1,528	1,738	1,738	1,372	1,676
6	693	769	742	564	761
7	313	365	295	235	333
8	151	175	121	81	120
9 or more	118	121	76	51	93
Total	**20,728**	**25,456**	**26,627**	**24,391**	**28,208**

Performance

Percentage of client cases with multiple services for which effective teamwork* (aspects of team formation and team functioning) is documented.

Aspect of Teamwork	FY 08 (n=10)	FY 09 (n=44)	FY 10 (n=43)	FY 11 (n=43)	FY 12 Est.	FY 13 Proj.	FY 14 Proj.	FY 15 Proj.
Team Formation	50%	82%	84%	81%	71%	83%	84%	84%
Team Functioning	30%	68%	79%	70%	82%	73%	75%	75%

*Effective teamwork is determined by a consensus rating of four or more on a six point scale by a team of reviewers after reading case records, conducting client and key informant interviews, and interpreting fact-finding results based on a standardized Quality Service Review (QSR) protocol.

Discussion

Although projections for FY13 and later are higher than the current year, the results of the QSR qualitative evaluation tool vary from review cycle to review cycle. This is due to the small and non-random sample of cases chosen for review. Therefore, it cannot be assumed that results will be consistently progressive.

By design, more complex and difficult cases were reviewed in FY11. This accounts in part for the dip in results between FY10 and FY11. In addition, the dip may be explained by increased reviewer training. Refresher training for reviewers was conducted in February 2011 and included a discussion of the need for greater rigor in the application of numeric scores. The difference between the scores for the 22 cases reviewed prior to the refresher training and the 21 cases reviewed after the refresher training was 20 percentage points (from 91% to 71%) for Team Formation. Similarly, the difference was 15 percentage points for Team Functioning. We believe this is a positive development and that results will better reflect the current state of team-based service delivery in FY12.

As more complex cases are moved into the integrated case practice model involving facilitated team meetings, goal setting, and case planning and action with caseworkers and clients, team collaboration and effectiveness is expected to improve. Attainment of FY10 levels is projected for Team Formation, and improvements approaching FY10 levels for Team Functioning.

Story Behind the Performance

Contributing Factors

- Team-based case management, a key element in the Department's Service Integration (SI) effort, involves staff coordination across programs in which a

client is receiving multiple services. Collaboration can be effective to set goals, achieve those goals, and share decision-making authority and accountability.

- In FY11, the Department began implementation and further development of an integrated case practice model with a target group of transition aged youth and young adults ages 16-24 from programs in child welfare, developmental disabilities, teen pregnancy and the Street Outreach Network. Team meetings involving service providers, and often the client, were convened to review and updated goals and assign action items to staff and clients where appropriate. Initial positive responses from staff and clients will be followed over time and include a re-review using the Quality Service Review process to determine changes in outcomes as a result of integrated team formation and functioning.
- Progress continued toward an information technology solution to create a common client index that shows all services provided to a given client based on a need to know. Work is underway to develop an electronic application system for selected DHHS programs.
- The Department also is engaged in a comprehensive process to assess the current information technology system and make improvements that lead to retrieving complete, unduplicated counts of customer volume.
- The Department finalized a conceptual case practice model for team-based case management that articulates the values and competencies that undergird the Department's approach to providing integrated services. This foundation work creates a standard approach and expectations for working within and across programs and services in DHHS.

Restricting Factors

- The lack of a regularly updated, searchable database of services, programs and personnel with contact information remained a key missing infrastructure element necessary for staff to operate effectively in an integrated service approach based on knowledge of and connections to the range of programs, services and staff in the Department.
- The lack of an interoperable information technology system that facilitates a common client index of all services received by an individual and allows high level case planning across programs impedes cross-discipline service coordination.

What We Propose to Improve Performance

- Implement the integrated services practice model for team-based case management with a target client population on a small scale in the Department.
- Use grant funds to continue development and implementation of integrated case practice model, protocols, training and tools to support staff and case practice.
- Develop and provide internal information resource directory of programs and services for staff, including contact information.
- Continue to improve intake, screening and referral process to support service integration.

- Monitor implementation efforts and provide support to staff in the move to a formal team-based case practice approach.

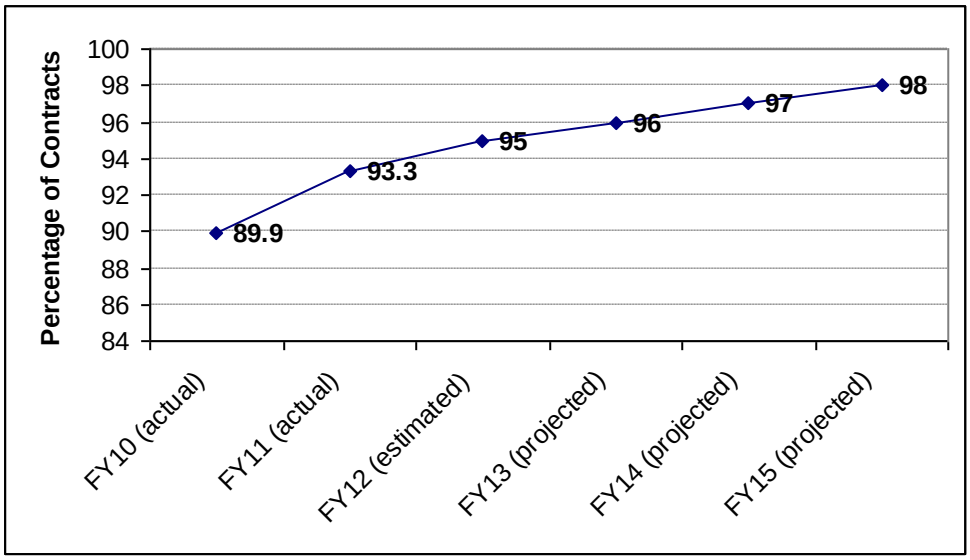
2. Contracted Services Performance Measurement

Basic Facts

- Performance measures increase accountability and provide a data-driven means for assessing the outcomes of a program or service.
- Performance measures are a mechanism for continuous quality improvement and therefore are more likely to result in better outcomes for clients.
- Performance measures provide data for future funding and contracting decisions.
- Measures focus on three aspects of beneficial Impact: risk mitigation, greater independence and/or improved health for customers.
- DHHS has over 530 contracts (competitive and non-competitive)
- Over $90M of services are procured through contracts (competitive and non-competitive)
- Beginning in FY10, performance measures were incorporated into new program-related Requests for Proposals (RFP) and resultant contracts. A count was made of the number of contracts derived from those RFPs in order to calculate the first result under this revised measure.
- Beneficial impact will be specific to the program and will focus on risk mitigation, greater independence, and/or improved health.
- Contributing data reflects contract status at a point in time, June 30, 2011. The universe of contracts fluctuates throughout the year as some begin and others end.

Performance

Percentage of current DHHS "health and human services" contracts derived from Requests for Proposals (RFPs) that contain performance measures related to beneficial impact and customer satisfaction.



Discussion

The FY 11 result is derived from dividing the cumulative number of current DHHS "health and human services contracts derived from RFPs that contain performance measures (98 contracts) by the total number of current "health and human services" contracts derived from RFPs (105). In this second year of the requirement, the Department advanced toward the 100% goal. FY11 performance exceeds last year's projection by one percentage point. The percentage of contracts for direct services with performance measures including beneficial impact and customer service will continue grow each year as new RFPs are issued until 100% is achieved.

Story Behind the Performance

Contributing Factors

- Within the existing process, expectations are identified in Requests for Proposals (RFP) and performance measures specific to the Service/Program area are included in final contract.
- Requirements are identified in federal and State funding streams.
- Outputs and deliverable timelines are well identified.
- Service Areas established Department wide definitions for contract performance measures related to both beneficial impact and customer satisfaction.

Restricting Factors

- Additional work is required to standardize policies and provide on-going training. Due to the general economic conditions and budgetary constraints, there are significant resource issues.
- Lack of technology to track performance on measures.

What We Propose to Improve Performance

- Continue efforts to refine program-specific performance measures for beneficial impact in partnership with DHHS vendors.
- Continue training Service Area staff on the development of and monitoring for performance measurement.
- Continue to review RFPs and contracts for inclusion of performance measures.

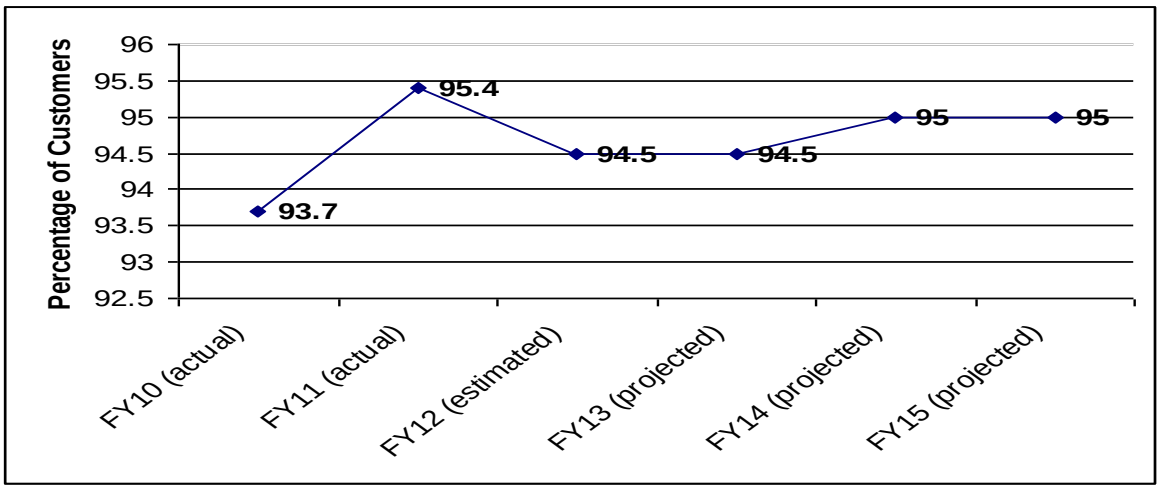
3. Customer Satisfaction

Basic Facts

- In FY11, DHHS staff encountered Limited English Proficient (LEP) clients 42,503 times and used over 9,182 telephonic interpretations, 353 per diem interpretations, over 3,722 vendor-provided medical interpretations, and 41 document translations.
- While customer satisfaction per se is not the primary intended outcome of human services programs, it is typically used as a proxy outcome that reflects the quality of services provided by an organization. The assumption is that higher quality services are reflected in a greater degree of customer satisfaction.

Performance

Weighted percent* of DHHS customers satisfied with the services they received from DHHS staff.



*A standardized customer satisfaction survey asked whether the respondent's needs were addressed, and whether he or she was served in a timely manner, treated politely, treated with respect, and overall satisfied with services received. The raw results for each program were weighted using the number of persons served by each program in FY11. The standardized survey was voluntarily used by 12 programs having recipients of services provided directly by DHHS staff. An additional 15 programs had at least one question on their customized customer satisfaction surveys that crosswalked to the questions on the standardized survey. Results from those questions were used in the composite.

The empirical literature is replete with the fact that some people will report satisfaction even when they are dissatisfied. Composite indicators (i.e., those in which multiple questions are collapsed into an overall score) are often cited by researchers as providing greater validity in capturing latent constructs such as "satisfaction", due to the ability to capture different facets of the phenomenon.

There were approximately 3,700 survey respondents. Those who provided demographic information were 56% male and 48% Hispanic. Thirty-four percent are under 19 and 13% are over 65, with all others in between. A full 43% chose "other" than Asian, Black or White as their race, suggesting confusion and/or inaccurate reporting. The programs contributing data to the composite result collectively served over 46,500 DHHS clients in FY11.

Submeasure: Weighted percent of DHHS customers satisfied with the language assistance (including sign language) they received when contacting DHHS.

For the result for the submeasure, see Discussion section below.

Discussion

Despite increased need in the County and reduced financial support from the State due to budget cuts, the percentage of satisfied customers has increased. Drilling down, the biggest increase (87% to 92%) pertains to staff work in addressing clients' needs. This may be attributable to extraordinarily high staff commitment to their work and clients. Despite the hardships, improved performance in customer service remains a focus.

The composite FY11 results for each of the five questions ranged from a low of 91.87% ("my needs were addressed") to a high of 95.42% ("I was treated politely"). Some programs deviated significantly from the average composite overall satisfaction scores. This is largely explained by the fact that some recipients of DHHS staff-provided services are receiving those services involuntarily.

Customers presenting with more complex needs for a range of services, anticipated strain in system capacity to respond to volume and depth of need, and a weakened infrastructure that continue to challenge DHHS ability to respond to increased need causes department to project a (less than one percentage point) decrease in customer satisfaction.

The survey also asks whether the respondent required language (or sign language) assistance when contacting DHHS and, if so, whether they received it and their degree of satisfaction with the assistance received. The result for the submeasure was 96.7% for FY11. However, the result is not statistically valid because more people reported satisfaction with language assistance (538) than reported actually requiring language assistance (458). We will revise the survey next year to ask the question in a different way to avoid any possible confusion.

Story Behind the Performance

Contributing Factors

- Highly trained and knowledgeable staff
- Staff proficiency in a number of non-English languages to facilitate service to LEP customers
- Staff knowledge of language resources provided by the department and appropriate use of resources to facilitate communication with LEP customers

Restricting Factors

- Many sources of dissatisfaction are outside of the control of DHHS (e.g., budget reductions which are likely to reduce the availability of many services, and applicants' ineligibility for program services)

- Large numbers of LEP residents and large diversity in languages spoken in the County

What We Propose to Improve Performance

- Continue to train select groups of DHHS staff in Customer Service, and encourage all staff to take Customer Service training offered by the County
- Continue to require new front-line staff to take Customer Service Across Cultures training
- Partner with Center for Study of Social Policy to offer customer service training to staff
- Evaluate impact of Program and Services Resource Guide information for staff, and improved Web site, on customer service

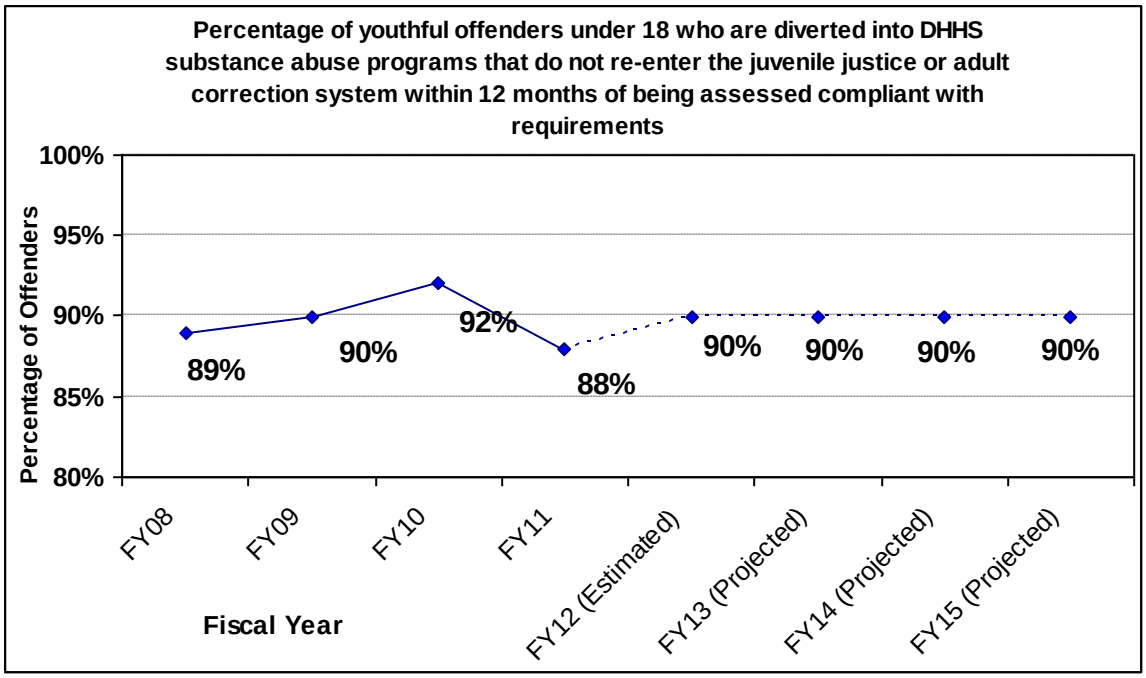
4. Juvenile Justice Assessments, Screenings and Referrals

Basic Facts

- National studies indicate that 50-70% of youth entering juvenile justice systems have substance abuse and/or mental health problems. Providing substance abuse and mental health screening, education and referral to treatment for certain first-time youth offenders and other repeat youth offenders whose offenses are minor will reduce the number of repeat youth offenders and minimize the number of youth referred to the Maryland Department of Juvenile Services (DJS) or the Maryland Department of Corrections.
- Three hundred forty-nine County youth under 18 received an alcohol citation.
- A total of 761 of the youthful offenders under 18 years of age who either received an alcohol citation (see previous bullet) or committed certain nonviolent misdemeanors (usually for the first time) were "diverted" from DJS to DHHS where they received substance abuse and mental health screening and referrals, if needed, to a drug and alcohol education program or mental health or substance abuse treatment. The top three citations or misdemeanors include alcohol citation, theft and simple possession of CDS (Controlled Dangerous Substance).
- Eighty-eight percent of youth diverted to DHHS by the Montgomery County Police Department (MCPD) were assessed "compliant" with the terms of their diversion agreement. Those who were non-compliant were referred to the DJS intake office.
- DHHS' Juvenile Justice Services unit partners with DHHS' Child and Adolescent Behavioral Health Services unit to provide mental health treatment referrals for Medicaid-eligible youth who are diverted.
- Twenty-four percent of diverted youth entered intensive substance abuse or mental health treatment; an additional 20% received intensive substance abuse education, including urinalysis, and 46% received less intensive substance abuse education. The remaining 10% were not referred to community services based on their assessment. These youth may have had to complete teen court or other requirements through MCPD.
- Eight work years and $920K were expended in FY 11 for operation of the Screening and Assessment Services for Children and Adolescents (SASCA), the alcohol and substance abuse screening program. This program assessed and referred a total of 1,515 juveniles in FY11.

Performance

Percentage of offenders under age 18 that are diverted to substance abuse education and treatment or mental health treatment programs that do not re-enter the juvenile justice or adult correction system within 12 months of being assessed compliant with requirements.*



*This measure is by definition a 12-month follow-up of juvenile justice clients; program completers are followed longitudinally from their completion dates. The reported recidivism rate is the outcome for the year in which the "follow-up" is conducted. Actual FY11 outcome data are based on follow-up conducted on clients who completed the program in FY10. Reporting on this measure occurred differently in the FY10 and earlier Annual Performance Plans, but is now consistent with the reporting method for recidivism rate for all criminal justice behavioral health programs at DHHS.

Discussion

Results reflect youth screened for mental health and substance abuse disorders and diverted from the Juvenile Justice System into community education and treatment services that did not become re-involved in the juvenile justice or adult correction systems within a 12-month follow-up period.

From FY08 – FY11, the result ranges between 88% - 92% with an average of 89.8%. The variation may depend on a number of variables including staff vacancies, number of participants referred/completing the program and complexity of cases. In FY11, twelve percent of the mostly first-time youth offenders who were compliant in FY10 with the SASCA program requirements became re-involved within 12 months. The FY12 estimate is based on the actual follow-up outcome of the successful program completers in FY10. For planning purposes, the out-years are projected to reflect FY12 results.

Story Behind the Performance

Contributing Factors

- An array of community-based substance abuse and mental health education and treatment services are available to youthful offenders.

- Good cooperation exists among DHHS, Montgomery County Police Department, DJS, the State's Attorney's Office and community substance abuse education and substance abuse and mental health treatment providers.
- Pre-established diversion eligibility criteria are based upon the severity of the offense, whether or not the youth is a first time offender, and whether the youth admits to the offense.
- DHHS has an 11-year track record in providing "diversion" services and an experienced substance abuse and mental health screening and assessment staff.
- A vacant Therapist II position was filled in February 2011 which increased the number of clients that could be served in SASCA.

Restricting Factors

- Underlying individual and family factors that result in criminal behavior are not always easily impacted; as a result, DHHS interventions are not always effective in preventing recidivism.
- The SASCA program has only one part-time case manager. Additional case management services could decrease the reoccurrence of offender behavior.
- SASCA had a vacant Therapist II position for 7 months in FY11.

What We Propose to Improve Performance

- Continue partnership with the Montgomery County Collaboration Council and the State to assure future funding for the case manager position. This position works with families to increase the number of SASCA diversions that become engaged in the diversion process, and increase the retention rate in treatment among diversion program participants.
- Continue to analyze Juvenile Justice Information System (JJIS) data for diversity trends and outcomes in diversion to ensure optimal performance by SASCA diversion program.
- Continue work with the Montgomery County Collaboration Council, the State's Attorney's Office for Montgomery County, and Maryland DJS to explore expanding eligibility to diversion in order to serve more youth and families, and divert more youth from DJS.
- DHHS' Behavioral Health and Crisis Services reorganized in the latter part of FY11, moving Child and Adolescent Behavioral Health and Juvenile Justice Services into one entity. This move will streamline services and offer clients a more seamless delivery of Mental Health and Substance Abuse services in line with the State initiative to combine the Department of Health and Mental Hygiene and the Alcohol and Drug Abuse Administration.

5. Direct DHHS Services

Basic Facts

- Determining the impact of receiving DHHS services is central to facilitating a successful outcome for the customer.
- Determining the impact on customers of receiving DHHS services is a management tool for ongoing quality service improvement.
- Based solely on Client Record System (CRS) data, 81,503 unique individuals received services from DHHS in FY11. "Services" includes both cases and encounters to apply for benefits that may or may not result in a positive eligibility determination.
- CRS data represent active clients that had a documented encounter with DHHS. The universe of active clients is higher for two reasons:
  - Clients who are active but who did not have a documented encounter in FY10 are not reflected in the data.
  - Although CRS is the largest DHHS database, there are several other mandatory state or federal databases of DHHS clients. Some individuals in other databases are not in CRS.
- The total of all individuals receiving services throughout the Department is unknown due to the lack of interoperable databases.
- In FY11, DHHS was budgeted for 1,348 full-time and 347 part-time staff for a total of 1485.8 work years. Contracted partners are also involved in serving customers within and across Service Areas.

Performance

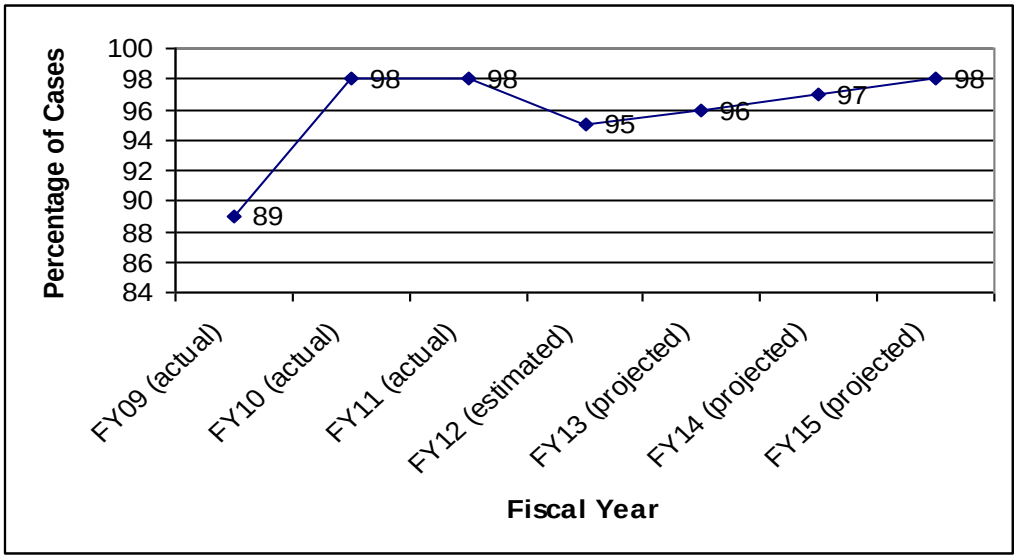
Weighted composite scores of DHHS program outcomes data that demonstrate (three different aspects of) beneficial impact from received services.

Aspect of Beneficial Impact	Weighted Composite Scores							
	FY08	FY09	FY10	FY11	FY12 Est.	FY13 Proj.	FY14 Proj.	FY15 Proj.
Improved Health and Wellness**	53.4	49.1	50.8	51.5	53	53	54	54
Greater Independence**	80	80.2	79.7	90.2	86	86	86	86
Risk Mitigation	80.4	84	83	83.7	84	84	85	85

*This first of two measures of beneficial impact is based on an algorithm that creates a Beneficial Impact Factor (BIF), which is derived from the dollars budgeted and the number of persons served by each of 20 programs that provide at least one measure to a mix of program measures of beneficial impact. Each of those 29 program measures is an outcome measure expressed as a percentage. The BIF enables DHHS to weigh each program's relative contribution to the beneficial impact of all of the DHHS programs represented in the mix. The weighted results are aggregated for each aspect of beneficial impact in order to arrive at the three final composite scores.

**The selection of programs for calculating these two aspects of beneficial impact was slightly revised from FY10 to FY11 to better reflect the scope of the Department's impact. Results for FY11 are for the new program selection, so are not strictly comparable to the previous years. Using the FY10 selection, the Improved Health and Wellness score for FY11 would have been 51.3, and the Greater Independence score would have been 90.1.

Percentage of client cases reviewed* that demonstrate beneficial impact from services received**



*** This second measure of beneficial impact is determined by a consensus rating of "substantial" or "fair" rather than "marginal", "no impact", "adverse", or "unknown" by a team of reviewers after reading case records, conducting client and key informant interviews, and interpreting fact-finding results by matching them to descriptions in a standardized Quality Service Review (QSR) protocol.

Discussion

First Measure

Although some program measures are in more than one aspect (e.g., both Risk Mitigation and Greater Independence), the Department uses caution when drawing conclusions based on comparisons across the three aspects and on relatively small fluctuations over time. These data, however, constitute a basis for looking more closely at program effectiveness as well as at the socioeconomic environment in which programs operate.

As measured by program outcome measures, beneficial impact remained stable in two aspects and rose significantly in the third (Greater Independence). This resulted primarily from the addition into the mix of the Welcome Back Center program, which greatly increased the wages of immigrant registered nurses.

Systemic improvements made as a result of QSR, IT Modernization and Service Integration are expected to have a positive impact on program outcome measures. However, the expected addition of new programs into the mix causes us to project only

modest increases in the two stable quantitative aspects and a slight decline in the third (Greater Independence) to a more typical level.

Second Measure
Despite reduced resources, beneficial impact, as measured by QSR assessments, remained stable and high. The overall exemplary result for this measure over the past two years tells a slightly different story when disaggregated. The proportion of QSR cases that showed "substantial" versus "fair" beneficial impact, as shown below, declined from FY10 to FY11.

We believe that FY11's lower substantially beneficial results reflect both the types of cases selected for review and refresher training provided to reviewers. Service Areas are encouraged to nominate challenging cases that may not be progressing as desired and that can benefit from an external and objective professional review. Refresher training for all reviewers on the QSR protocol in February 2011 emphasized the importance of objectivity in rating performance. Prior to February, reviewers assessed the beneficial impact as "substantial" in 73% of the 22 cases reviewed, a result similar to the FY10 breakdown. After February, however, only 55% of the next 22 cases reviewed received the "substantially beneficial" rating. We view this development as positive in that a more accurate picture of beneficial impact is likely for FY12; this measure will show a slight decline as reviewers continue to perform more rigorous assessments.

Degree of Beneficial Impact (BI) from Quality Service Review Data over Time

	FY09	FY10	FY11
Substantial BI	65.9%	74.4%	63.6%
Fair BI	25.0%	23.3%	34.1%
Lesser Degrees of BI	9.1%	2.3%	2.3%

Story Behind the Performance

Contributing Factors

- Quantification provides the impetus for increasing beneficial impact over time and for analyzing factors that affect the scores.
- Development, testing and implementation of the QSR protocol for qualitative assessment has led to active planning for the improvement of system performance to the benefit of DHHS clients.
- Expectations for case management, including intake and referral, assessment, case planning, service delivery and evaluation are strong and monitored by the Quality Service Review process.
- Implementation and continuing development of an integrated DHHS case practice model is underway that will incorporate improvements in system performance based on QSR results.

- County, state and federal budget cuts to programs reduced the number of staff to serve increased numbers of clients seeking services during the economic downturn.
- Best practice models are used in many programs.
- Four QSR review cycles were conducted over the year.

Restricting Factors

- Knowledge about service integration and the team-based case management model is inconsistent throughout the Department.
- There is a need to continue to enhance the capacity to collect, analyze, store and report data to support continuous improvement in service delivery.
- The needs of a population adversely affected by economic downturn again increased in intensity while public resources continued to diminish. Clients are presenting with more complex needs and for a wider range of services.
- The capacity of our system was again strained in responding to the volume and depth of need, and our infrastructure was again weakened by budget cuts.
- Evidence-based Practices empirically validated as effective in addressing some social problems are limited in number.
- Resources (staff and funding) from external sources are needed to make substantial progress on interoperability.

What We Propose to Improve Performance

- Continuously seek efficiencies to deal with pressure on the system to serve more people with ever-decreasing resources.
- Monitor implementation efforts and provide support to staff in the move to a formal team-based case practice approach.
- Continue work to define equity, social justice and institutional racism to better address disparities in (and disproportionality among) residents needing and seeking certain services.
- Provide resources (staff and funding from external sources) as available to make significant strides in information technology interoperability.

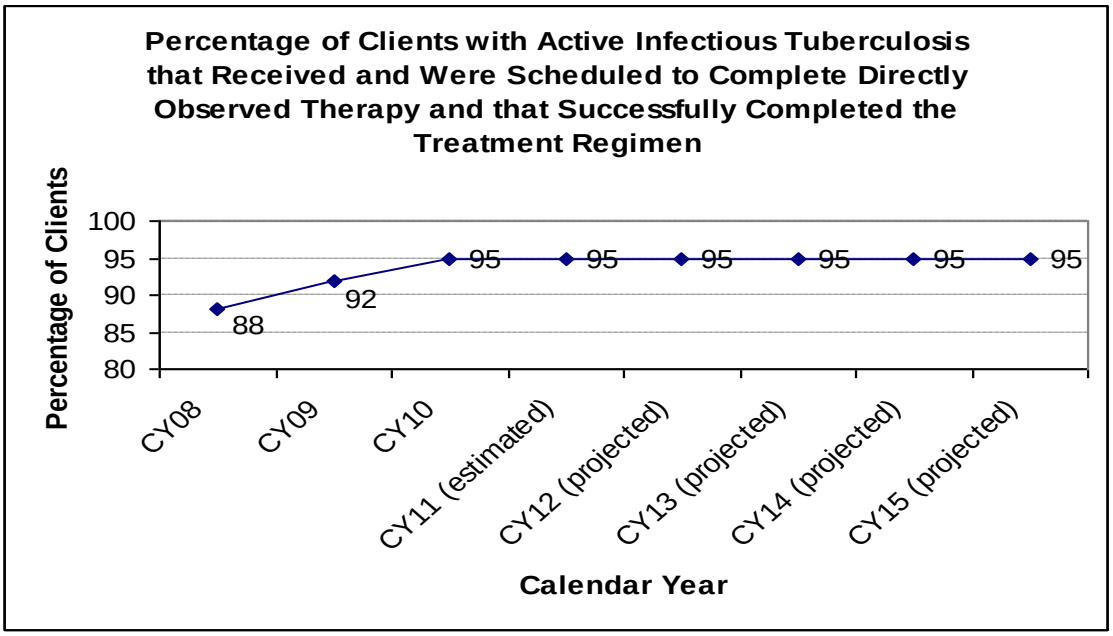
6. Communicable Diseases Control

Basic Facts

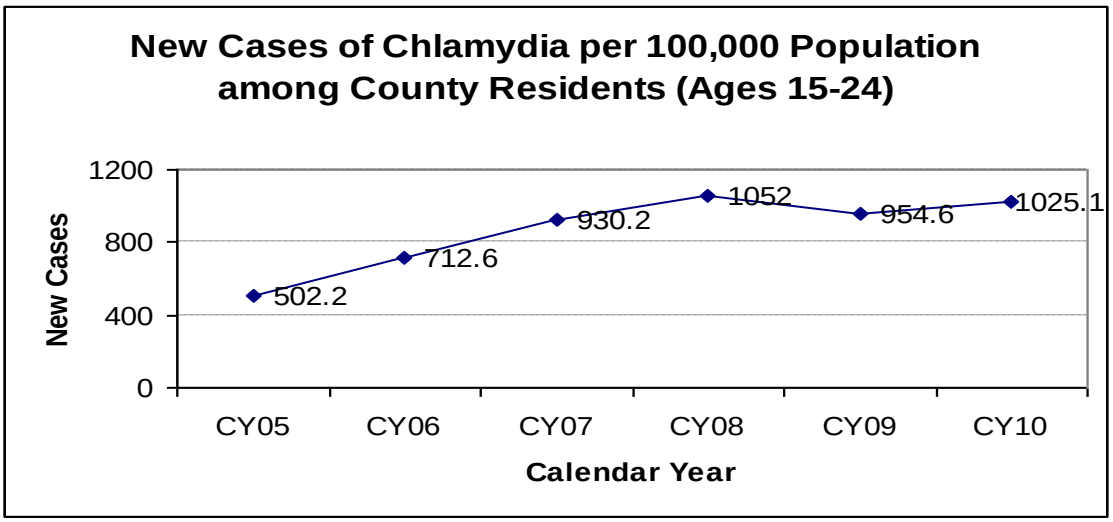
- The public is protected from communicable diseases by limiting their further spread.
- DHHS programs provide timely and appropriate response to reports of communicable diseases.
- DHHS programs provide access to prevention, diagnosis/early intervention and treatment of communicable diseases for at-risk (exposed) individuals.
- DHHS educates the public on best practices to further limit the spread of disease and protect the health of individuals.
- Annually, within Public Health Services (PHS), there are over 400 foodborne complaints/investigations (including Campylobacter, E.coli, Hepatitis A, Salmonella or Shigella); 2,200 communicable disease cases (including vaccine-preventable diseases, rabies exposure, Lyme disease, and bacterial meningitis); 75 active tuberculosis (TB) investigations involving approximately 1,000 individuals; and 542 sexually-transmitted diseases (STD) investigations, including Chlamydia, Gonorrhea, HIV and Syphilis.
- In FY11, there were 250 suspected cases of TB evaluated, with 73 cases requiring and undergoing treatment. There were also four large scale TB investigations (all in institutional settings).
- The DHHS TB program annually manages approximately one out of every 150 of the national TB cases (approximately 33% of Maryland cases).
- In FY11, the DHHS Immunization Program administered 16,976 vaccines to 8,205 children; 11,892 doses of seasonal flu vaccine and were administered to County residents.
- Timeframes and workload for outbreaks vary based on severity and mode of transmission of the contagion. A single outbreak may be resolved in a few days or three months. Smaller outbreaks are managed by one investigator but larger outbreaks require 8-10 investigators to control.
- Foodborne diseases and Illnesses are being addressed in an integrative approach with Licensure and Regulatory Services.

Performance

Percentage of clients with active infectious tuberculosis that received and were scheduled to complete Directly Observed Therapy and that successfully completed the treatment regimen



New Cases of Chlamydia per 100,000 Population among County Residents (Ages 15-24)



Discussion

First Measure

TB in Montgomery County occurs at dramatically high rates (twice the statewide and national averages). The largest number of cases in the state is found here. This is due to the large number of immigrants who arrive from countries where this disease is prevalent. Montgomery County's TB case count is sensitive to fluctuating immigration rates. Anecdotal evidence points to a decrease in immigration and increase in immigrants moving out of the county for economic reasons in CY09. In CY10, there

seems to be a slight increase in foreign born clients; most of the TB cases (93%) are foreign-born.

In CY10, those 4 (of 73) clients who did not successfully complete the TB treatment regimen died before diagnosis or treatment was completed.

Second Measure
There is a small uptick in the Chlamydia rates which reflects natural disease patterns. It may also reflect greater reliance on presumptive diagnoses rather than confirmed lab testing (which has decreased since 2008). DHHS chooses not to estimate future results for new cases of Chlamydia because of uncertainty over whether the decline in case numbers is the result of decreased exposure to the disease or decreases in screening populations at risk. At some point when awareness is elevated to screen all populations at risk, Chlamydia incidences should begin to fall as a result of decreased exposure to the disease resulting from such program activities as community education and partner notification.

Story Behind the Performance

Contributing Factors

- PHS engages in multiple activities designed to: prevent disease from occurring through immunization, outreach and education programs; identify/diagnose disease through education, screening, and diagnostic evaluations; treat diagnosed diseases using the most effective prescribed protocols; and limit the further spread of disease with education, outreach and partner/contact notification for persons exposed to contagion.
- Quick response time to outbreaks and emerging diseases is the norm.
- Education, trust and regulatory authority are used to ensure persons with illness are consistently practicing healthy behavior, with emphasis on completion of treatment and adherence to treatment regimens.
- Immunizations are offered to county residents of all ages in a variety of settings and after hours.
- The County operates a strong emergency preparedness program, including exercises and training, recruitment of community volunteers (e.g. Medical Reserve Corps) and development of plans for public health emergencies
- Intensive medical and nurse case management of diagnosed diseases is provided.
- Aggressive strategies are in place for contact tracing and partner notification.
- Public health investigations follow federal and State guidelines for controlling communicable diseases, using sound epidemiological principles.
- To rule out TB, the TB control program provides screening to contacts of infectious cases of TB, newly arrived refugees, immigrant students prior to admission, County residents per job classification, inmates at the Detention Center, clients entering substance abuse centers, and symptomatic residents who walk into the clinic. The clinic also coordinates TB screening with the homeless shelters and provides treatment for latent TB infection to high risk individuals with the appropriate intervention/follow up.

- The TB Program successfully manages a number of drug resistant cases as well as some cases of multi-drug resistant tuberculosis (MDR-TB) where treatment can extend to two years.

Restricting Factors

- Public perception of risk is often inconsistent with actual risk, with the potential of untreated communicable disease presenting high risks to the general public.
- Funding issues have led to staff shortages in Communicable Disease and Licensure and Regulatory areas, which investigate foodborne disease outbreaks.
- Adult vaccine clinics were discontinued in FY10 due to lack of space and staff to provide the service.
- Public health is challenged to find a balance to motivate people to have safe and prudent behavior versus overreaction, restriction and seeking unnecessary treatment.
- County residents without legal status fear seeking medical care and consequently present with advanced disease.
- Starting in 2009, in accordance with State guidelines, the State laboratory covered the processing costs of Chlamydia tests for women 25 years and younger. Women 26 and older, and all males who present with symptoms or report contact with a case will be treated following Chlamydia treatment guidelines, but will not be tested (unless the submitting site covers the testing expense). For those untested cases, there will be no trigger to initiate contact tracing or any retesting.
- With the addition of two STD Service satellite clinics per week in Germantown, the turn away rate for these services has decreased by approximately 70% on average in 2010-2011.
- Compliance with TB directly observed therapy (DOT) relies heavily upon the client's ability to remain in DHHS service area for the duration of treatment.
- DHHS continues to provide services to clients in accordance with appropriate protocols; however, revenue from general funds continues to decrease annually. With fewer resources, DHHS will not be able to respond in a timely manner to all presenting cases, nor will it be able to provide the full spectrum of services and delivery of care previously available to meet the needs of the community. Thus, future cases may be identified in more advanced stages of disease and resultant complications. This may potentially lead to increased illness and death.
- There is an increase in co-morbidity among communicable diseases (e.g. co-infection with HIV and syphilis).

What We Propose to Improve Performance

- Improve internal process for completing reports on closed cases to DHMH.
- Provide education/outreach on preventing and limiting the spread of communicable diseases by providing consistent cultural and language appropriate messages on aspects of health topics to improve public awareness and trust in DHHS services.

- Continue to invest in relationships with key partners, including efforts to implement a community health assessment involving local public health system partners and use information from this assessment to develop a Community Health Improvement Process (Healthy Montgomery).
- Continue to assess changing needs of the community and develop innovative ways to address those needs, such as increasing access via evening clinic hours.
- Advocate for additional revenue to compensate for shortfall from grant awards. With less operating revenue for grants, most or all grant funds go toward personnel costs.
- Advocate for opportunities for screening, treatment, education and counseling/case management, specifically for the STD clinic up-county.
- Improve internal process for managing patient flow.
- Advocate for resources to train staff on best screening, counseling and treatment practices.

7. Social Connectedness and Emotional Wellness

Basic Facts

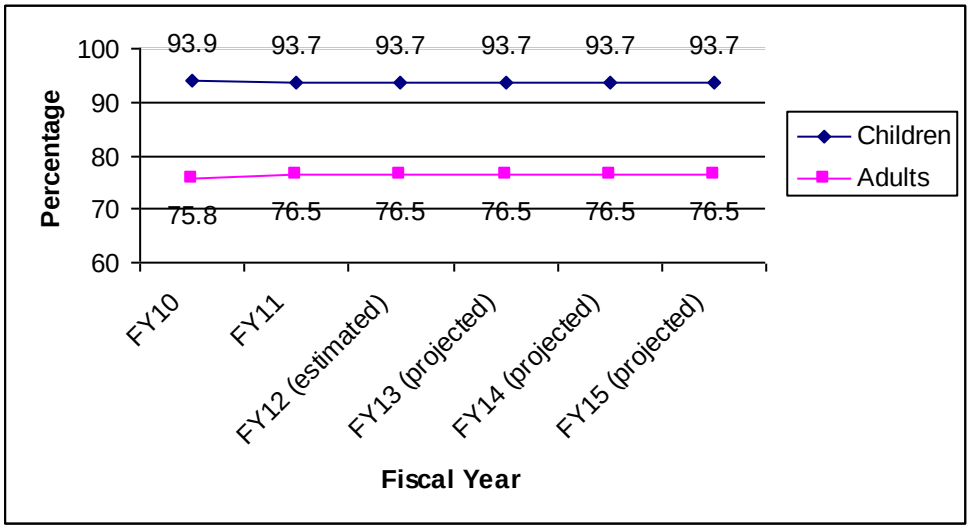
- DHHS supports a comprehensive system of behavioral health (mental health and substance abuse) treatment services to children, youth, adults, seniors and families through community partnerships, contracting and directly-operated services. Services incorporate evidence-based practices (EBP) and targeted preventive intervention along a continuum of care.
- Crisis and victim services are available around the clock to clients victimized in schools, homes and in the community.
- Access to Behavioral Health Services provides information, screening and referrals to appropriate mental health or substance abuse services for consumers, particularly those without commercial medical insurance.
- Services to clients with public health insurance and priority populations are monitored, including outpatient mental health clinics, senior outreach, homeless outreach, psychiatric rehabilitation and residential rehabilitation programs.
- In FY11, the Crisis Center served a total of 49,650 contacts including 46,950 phone contacts and 3,534 walk-in contacts. A total of 569 students were referred by their schools to be assessed for level of risk to themselves or their community; 94.7% of these students did not require emergency department services, were stabilized in the community and could return to school.
- During the five years from 2005-2009, an average of 1,465 individuals in Montgomery County reported an incident of domestic violence to legal authorities annually, accounting for 7% of all domestic violence incidents statewide. A total of 1,642 victims in Montgomery County in FY11 were referred to the Abused Persons Program (APP) for domestic violence services. In FY11, APP answered 2,437 hotline calls, saw 1,736 total new victims face to face and reported 3,060 volunteer hours. APP staff conducted Domestic Violence trainings and presentations to 275 people, professional staff and community members. A total of 5,835 services in FY11 were delivered in the Abuser Intervention Program which includes men and women in both individual and group sessions.
- A total of 3,871 sexual assault and general crime victims received services from the Victim Assistance and Sexual Assault Program. Additionally, there were 150 outreaches to sexual assault victims, assisting 310 victims and their loved ones in FY11. All rape victims were offered advocacy and counseling by trained and supervised volunteers who respond directly to police stations or the hospital. The Victim Assistants provided court accompaniment and court advocacy to 841 crime victims.
- In FY11, the Clinical Assessment and Triage Services (CATS), one component of the DHHS Criminal Justice programs, in collaboration with Department of Correction and Rehabilitation (DOCR) staff, oriented and screened 9,385 offenders entering the Montgomery County Detention Center to determine suicide risk.
- The Child and Adolescent Mental Health Home-Based Team served a total of 115 children in FY11. Of those served, 99% were able to be maintained in the

current placement. Less than 1% (n=1) of the children had to be referred to out-of-home care. The number of children served by the Home-Based Team in FY 11 decreased from the previous year due in part to the transferring of one work year in FY10 to the Child and Adolescent Outpatient Clinic to address the Spanish speaking waitlist and the resignation of a staff member on the Home Based Team. The clinic served 328 children in FY 11 with less than 1% needing to placed out of the home (n=2).

- From FY10 to FY11, the number of Montgomery County consumers accessing the Public Mental Health System grew by 7.2% from 9,679 to 10,375. This upward trend is expected to continue given the uncertain economic times, increasing Medicaid enrollment and an increasing number of returning veterans needing services.
- The Adult Behavioral Health (ABH) Program provides a comprehensive range of mental health services including assessment, diagnostic evaluation, psychotropic medication, evaluation and medication monitoring. In FY11, ABH received 90 referrals from the Access Team, of which 71 cases were admitted. Thirty percent of ABH clients responded to an anonymous customer satisfaction survey available in three different languages and gave the program an 85% positive rating. Self-administered Symptom Checklists were completed by ABH clients in FY11, and 87% of the 203 clients who completed a Checklist reported a reduction in symptoms.

Performance

Percentage of individual clients served by the continuum of behavioral health services that demonstrate a higher degree of Social Connectedness and Emotional Wellness as demonstrated by positive outcomes in the domains of housing, quality of life, legal encounter, and employment/education*



*Computation of composite scores focus on Outpatient Mental Health Clinics' (OMHC) outcome measurement data collected by Maryland's Department of Health and Mental Hygiene (DHMH) on individuals ages 6-64 receiving outpatient mental health treatment from OMHC, Federally Qualified Health Centers and hospital-based mental health centers. Due to the Outcome Measurement System (OMS) contractor change, starting in FY10 the questionnaires used for interviews were changed substantially, so

comparison of FY10 and FY11 results with FY09 is not meaningful. For example, compared to previous years' figures, the prevalence rate for alcohol and drug use measured by the new scale is 10-20 points higher in FY11. However, the increased prevalence does not necessarily indicate an upward trend in alcohol and drug use by clients interviewed.

Also due to the adoption of the Version Two OMS questionnaire in FY10, the FY11 OMS data report excludes two of our original eight individual measures including the measure for housing stability and negative legal encounter. Additionally, the original measures for alcohol use and drug use were combined into one measure. Consequently, five measures downloaded from OMS Data Mart are applied to computation of the composite score to demonstrate consumer self-reported improvement in housing, employment/education, legal encounter, and quality of life outcomes. These domains represent a full spectrum of consumers' treatment and recovery experiences. The scores for each of four domains of social connectedness are summarized in the form of a weighted mean of percentages to obtain overall composite scores for children and for adults. The weight used in calculating the weighted mean is the sample size for each of the five questions in the OMS survey.

In FY11, 3345 adults (53% of all adult outpatients) ages 18-64 years accessed outpatient services at OMHCs and completed an OMS questionnaire. Additionally, outcomes data was collected on 2379 child and adolescent consumers aged 6-17 years (57% of all child and adolescent consumers).

Discussion

Two separate composite scores were computed for adults and children. The Employment/Education domain measures (Staying in School for children and adolescents, and Gained/Retained employment for adults) are two major drivers for the large gap in scores between these two groups. The difference in the scores for the two groups is primarily attributable to the very low employment rate among adult consumers.

FY11 performance is relatively consistent with that of FY10. DHHS expects to see relative consistency from year to year given the nature of the population served. Through FY13, projections will likely remain consistent with that of FY11. The implementation of Health Care Reform is likely to impact on this measure beginning in FY14. Because of the unknowns in Health Care Reform, DHHS is not forecasting a significant percentage change.

The key message conveyed by this year's outcome data is that 76.5% of the County's mentally ill adult population and 93.7% of its mentally ill child and adolescent population with Medicaid coverage reported they have experienced positive outcomes in the area of housing, employment/education, legal encounter, and quality of life as a result of a comprehensive array of behavioral health services they received in the County.

Story Behind the Performance

Contributing Factors

- A continuum of comprehensive community-based substance abuse and mental health treatment services is available to individuals across the life span.
- Strong collaborative partnerships exist between DHHS, Montgomery County Public Schools, Montgomery County Police Department, Department of

Juvenile Services, DOCR and community providers to support a comprehensive system of care.
- DHHS provides well established County-operated crisis services.
- DHHS has a strong commitment to delivering services that are recognized either as evidence-based or promising practices.
- In FY11, the ABH Program continued to promote ongoing training and efforts to integrate EBPs including Motivational Interviewing; Illness and Symptom Management, Wellness Recovery Action Planning and Co-Occurring Disorders.
- In FY 11, fifteen Child and Adolescent Behavioral Health staff received additional training in Motivational Interviewing and are incorporating these techniques into their practice. Rates of treatment compliance have increased.

Restricting Factors
- An adequate data system is needed in support of business operations and electronic record keeping to effect sound, data-driven decision making.
- A shortage of bilingual providers in the Psychiatric Rehabilitation Program, Residential Rehabilitation Program and other behavioral health programs to assist non-bilingual clients with collateral services such as vocational programs, housing and life skills programming.
- Lack of access to affordable and appropriate housing.
- Lack of transportation resources and transportation assistance for clients that live up-county to access alternate services in that area.
- Inadequate level of services in the community for some bilingual and uninsured or undocumented clients who are psychiatrically stabilized but in need of ongoing medication management.
- With the stagnant economy the need for public services has increased. Child and Adolescent Behavioral Health has had a waitlist for FY11 which has decreased the ability to respond quickly to requests for services.
- The increasing need for behavioral health services by undocumented individuals poses significant challenges for county-run programs to locate community treatment services that would help to stabilize these individuals and assist in prevention of future hospitalizations.
- Lack of treatment services for special population groups such as transgender individuals. In FY11, our Core Service Agency Behavioral Health Planning and Management office faced challenges in finding local treatment services for these individuals.
- Systemically, the need to develop the ability to serve individuals who have needs that fall across somatic, developmental disabilities, and behavioral health domains yet who do not clearly meet the medical necessity criteria for any particular domain.
- Continued budgetary challenges.

What We Propose to Improve Performance
- Increase number of providers in the community that are trained in EBPs.
- Increase provision of health education and psycho-education in several languages to clients served in DHHS' Behavioral Health and Crisis Services (BHCS) programs or by providers in the community.

- Continue ongoing collaboration with and encouragement for client participation in activities at Wellness and Recovery centers and other peer run groups.
- Train BHCS frontline clinical staff in brief therapy techniques as well as motivational interviewing techniques.
- Initiate a comprehensive review of current BHCS program outcome measures and appropriately revise methods for collecting outcome data to capture status and trends accurately and inclusively.
- Continue ongoing data analysis projects of various databases including Public Mental Health System Paid Claims data and Health Services Cost Review Commission Inpatient Admission data to monitor the service utilization pattern/trend and the prevalence of co-morbidity issues for the county's mentally ill population.
- Continue to seek opportunities to integrate somatic health care and behavioral health care services through expansion of behavioral health care to more Montgomery Care clinics and collaboration with Primary Care Coalition Clinics to promote such integration.
- Continue to seek opportunities to further integrate mental health services and substance abuse treatment services and eliminate barriers to service provision, system resource planning and monitoring of quality of services.
- Continue to partner with the Department of Technology Services for Geographic Information Systems Services as part of ongoing efforts at improved data collection and informed forecasting of service needs.
- Continue to collaborate with DHHS' Information Technology and the County's Department of Technology Services to improve data systems which would enable managers to utilize timely and accurate program data reports and review current outcome data to improve performance and utilize resources towards maximum efficiency.
- Provide interim housing for individuals with behavioral health needs who are not able to live in shelters or who are too stable for residential crisis services.
- Advocate for implementation of a Residential Habilitation Services Model under the Fee for Service System, where individuals can age in place but not be required to participate in rehabilitation activities.
- In FY12, with the reorganization of BHCS, Criminal Justice Behavioral Health Services (jail based treatment) will serve more exiting inmates who need linkages to community based treatment and other resources, ensure earlier identification of needs for services, and support more inmates re-entering society.
- Clinical Assessment and Transition Services, located in the Montgomery County Correctional Facility, provides reentry services to identified exiting inmates in support of the direct transfer of their cases to community based treatment resources. Screening and assessment services were provided to inmates entering DOCR for identification of behavioral health needs.
- Increase opportunities for individuals with behavioral health disorders to live successfully in, and remain in, the community.

8. Access to Healthcare

Basic Facts

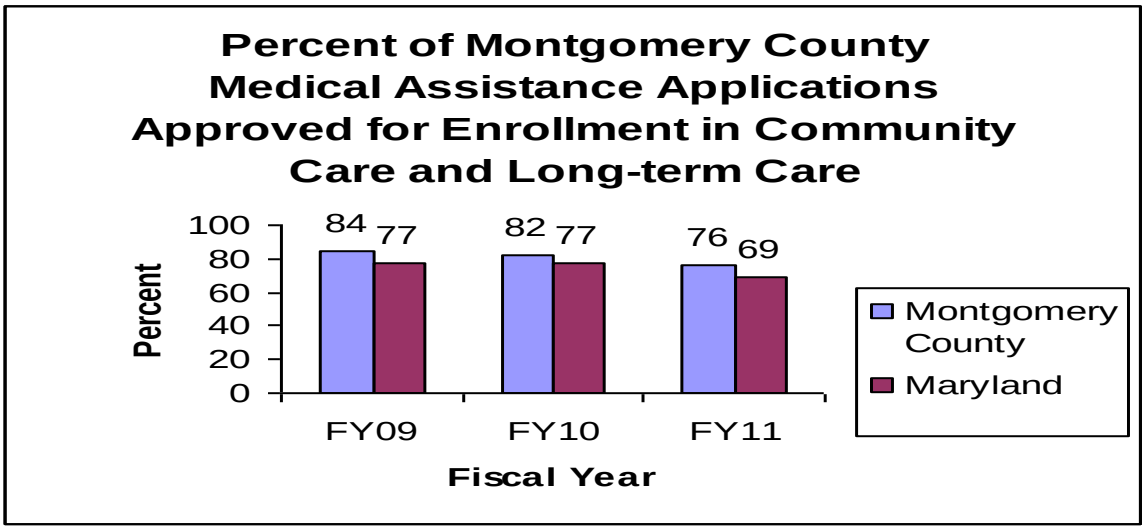
- Montgomery County had 121,447 uninsured residents in 2010, including 10,475 children. Approximately 38,000 children and 24,500 adults 18-64 years of age were covered by some public health insurance option (including Medicaid, Medicare, or other government assistance plans).
- Providing access to health care to all residents has many benefits: healthier, more productive residents; less absenteeism from school or work; more disease prevention, earlier detection and better management of diseases such as asthma, diabetes, cancer and heart disease, and cost savings that arise from prevention and more appropriate use of hospital emergency rooms for true emergencies.
- Montgomery County has led the way in the State and is probably one of the few jurisdictions nationally to attempt to address the issue of access to health care at the local level.
- The DHHS Service Eligibility Units (SEUs) process medical assistance applications for the Medicaid for Families program and the Maryland Children's Health Program that are funded and administered through the Maryland Department of Health and Mental Hygiene (DHMH) to cover minor children under the age of 21 and their parents or caretaker relatives and pregnant women. SEUs also process applications for Care for Kids, the Maternity Partnership, and Senior Dental.
- Additional Medical Assistance coverage groups that fall under the Aged, Blind, and Disabled (ABD) and Families and Children (FAC) categories are administered by the Maryland Department of Human Resources and processed by the DHHS Income Support program, along with eligibility for other public assistance programs like Food Stamps, Temporary Assistance for Need Families, and Temporary Disability Assistance.
- In FY10 DHHS processed 78,176 medical assistance applications and 7,841 county healthcare program applications. Of these, 58,464 medical assistance and 7,620 county health care programs applications were approved. Currently, the three SEUs lead the state in the number of enrolled medical assistance cases, which averages 40,292 monthly. In the same year, Income Supports offices processed an additional 40,539 applications for other forms of public assistance.
- DHHS staff enrolled 2,931 uninsured children, who are not eligible for State or federally funded programs, into the County's Care for Kids program in FY11 and enrolled an additional 1,950 pregnant women in the Maternity Partnership to ensure access to prenatal care and delivery services. The Montgomery Cares Program provided access to primary health care and prescriptions plus limited specialty care to 26,877 uninsured adults in FY11.

Performance*

Percent of select uninsured vulnerable populations that have a primary care or prenatal care visit

Populations	FY09	FY10	FY11
Children	34.7	41.4	27.9
Adults	21.3	25.7	24.2

Percent of Montgomery County medical assistance applications approved for enrollment.



*The Department is not projecting results for FY12 and beyond at this time due to the multiple variables related to health care reform.

Discussion

First Measure

While Care for Kids enrollment decreased 13%, the estimated population of children without health care coverage increased by 22% from 2009 to 2010. The Care for Kids program serves primarily the children of immigrants who do not have the documentation needed for MA coverage. The percentage of uninsured children with access to health care through the program may have been affected by the following demographic shifts:

- Low income, uninsured children increased as a result of the downturn in the economy and the related reduction in jobs, including jobs with health insurance benefits.
- Enrolled uninsured children decreased, probably due to immigrant families having temporarily moved out of the County or temporarily stopped coming into the County due to high cost of living and lack of unskilled jobs available during the economic slowdown.

In FY11, the Montgomery Cares clinics increased the number of patients served by 2% from 26,268 to 26,877.

Second Measure
In FY11, 42,008 new applications were submitted for enrollment into Maryland's medical assistance programs (Community Care and Long-Term Care) with 31,958 applications (76%) approved. The FY11 average approval statewide was 69%. Medical Assistance (MA) approval rate variables include patients' timeliness in completing the application process and the workload capability of staff. It may also be due to larger numbers of people who are unable to afford health insurance premiums but who still make too much income to qualify for MA programs.

Story Behind the Performance

Supporting Factors

Eligibility

- DHHS enrolls uninsured residents who are not eligible for State or federally funded programs into the County Care for Kids program or refers adults to the County's Montgomery Cares program to ensure access to primary health care and related prescriptions, or to the Maternity Partnership Program for prenatal care.
- County residents may enroll in specific health care access programs at multiple sites.
- SEU procedures were streamlined to accommodate the 2008 family Medicaid and the 2009 Children's Health Insurance Program Reauthorization Act policy expansions.
- DHHS provides language interpretation for large numbers of applicants with Limited English Proficiency. In addition, the Department supports residents in using an online application to enroll in medical assistance programs. Health Promoters from the community and other outreach staff also help to link residents to health access programs.

Education

- DHHS provided medical assistance/County healthcare programs outreach training and activities across the County throughout the year serving specific geographical and cultural communities including Linkages to Learning, school based health centers, Holy Cross Hospital multi-cultural healthcare promoters, and infant mortality reduction healthcare promoters in FY10 and FY11.

Funding

- County leadership continues to support the current capacity for Montgomery Cares clinics for uninsured adults; a large number of volunteer medical providers contribute time to support Montgomery Cares; additional specialty care providers contribute discounted care; and local clinics and hospitals contribute services and facilities.
- Enrollment of eligible County residents in State and federally-funded health insurance programs - including medical assistance and similar programs- leverages County dollars for enrollment workers with State and federal dollars to cover health care administrative costs. Hospitals cover half the cost of County eligibility staff working in the hospitals, and State grants and federal reimbursement cover full or partial costs of many County eligibility staff.

Staffing

- The FY11 budget included funding for three new eligibility workers for the Medical Assistance eligibility programs. Once these and a fourth current vacancy are filled, it is expected to result in the identification of additional Montgomery Cares patients who are eligible and will enroll in either Medicaid or the State's Primary Adult Care program.

Restricting Factors

Eligibility

- State and federal agencies establish eligibility criteria for entitlement programs that limits enrollment.
- Proof of citizenship or appropriate resident alien status that is required to obtain federal/state medical assistance presents challenges for applicants and additional work for staff.

Education

- Many residents are not aware they are eligible for a federal/state program, which results in higher unmet demand for County safety net programs.

Funding

- A lack of funding prevents sufficient staffing and office resources to sustain increased medical assistance caseloads.
- The Montgomery Cares, Maternity Partnership, and Care for Kids programs currently have limited funding and capacity to meet the demand for services should every eligible low-income uninsured person enroll.

Staffing

- DHHS does not have sufficient eligibility staff to adequately process new and renewal applications within prescribed timeframes, resulting in delays and additional expense to individuals, hospitals and the County.
- 26 SEU caseworkers are responsible for maintaining a monthly average of 1,707 cases each in order to sustain 42,664 federal and county actively enrolled cases. Currently, the SEU staff receives a monthly average of 5,500 (66,000 annually) new county and federal applications to be processed.
- Income Support caseworkers are generalists responsible for servicing medical assistance benefits along with the cash assistance and food supplement benefits for the same families. Eighty-seven caseworkers are responsible for handling these combined caseloads with an estimated 60,000 ongoing assistance units each month and an average of 2,280 new applications for medical assistance each month.

Information Technology

- Seamless interoperability and integration of medical assistance and County-specific healthcare programs eligibility screening and processing is needed to improve efficiencies and to provide accurate caseload and client demographic information.

What We Propose to Improve Performance

Eligibility/Information Technology

- Continue to streamline procedures for residents applying for programs; advocate for resources to develop and implement an integrated and

interoperable medical assistance and County-specific computerized eligibility system.

Education

- Increase individual awareness of eligibility for medical assistance programs through the MC311 information line and updates to the County web site, by continuing to support online information about resources available to County residents through the Collaboration Council's www.InfoMontgomery.org, and by providing information in multilingual formats like the Montgomery Cares web site (www.MontgomeryCares.org) and brochures.
- Advocate for and train additional volunteer Health Promoters to assist residents in applying for available publicly-funded health insurance/primary care programs.

Funding

- Advocate for funding to support sufficient staffing and office resources to sustain increased medical assistance caseloads.

Staffing

- Advocate for hiring and training additional eligibility workers as supported by workload data. The actual number of people enrolled that also require caseload management is far greater than the number of applications processed since applications are typically initiated by the head of household and the average household usually includes two or more minor dependent children.
- Advocate for resources to increase administrative support and caseworker staffing to provide timely processing of client applications, effective caseload management, adequate case record filing and storage management, and dedicated staff to address and resolve client issues.

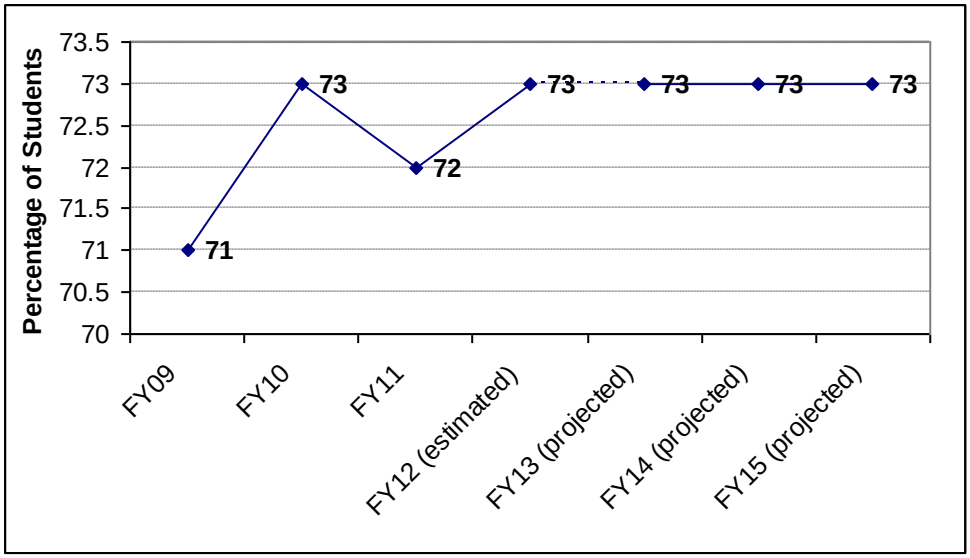
9. Early Childhood Services and Programs

Basic Facts

- The U.S. Census Bureau in its American Community Survey estimates that, in 2009,:
  - 82,000 children under age six lived in Montgomery County;
  - There were approximately 111,000 families with children; 43% of these families had young children under age six;
  - 56,000 children under age six had both parents in the labor force;
  - Over 22,000 children under age six lived in families with low incomes (less than 200% of poverty level) in 2009, a 73% increase since 2000.
- There were 13,493 births in 2009, according to the Maryland Vital Statistics Administration.
- Early Childhood Services documented that 112,201 services were delivered to young children, their families and caregivers in FY11, down from 163,229 in FY10. These services include a wide variety of publicly-funded supports, for example home visiting to at-risk families, workshops for child care providers to enhance the quality of care, health screenings for young children from low income families, Library Story hours, Recreation Department programs, and outreach to help families find the resources they need. In FY11:
  - The Montgomery County Infants and Toddlers Program served 4098 families, an increase over the previous year's 3,951.
  - 693 children were enrolled in Montgomery County Head Start, with a funded enrollment of 648.
  - 2,389 four-year-old children were served in the MCPS Pre-Kindergarten program.
  - 4,895 health screens for newborns were conducted in hospitals by the Baby Steps program contract staff.
  - 2,862 program referrals were made to early childhood and family support services by CHILDLINK staff.
  - 606 child care providers received workshop training through the Montgomery County Child Care Resource and Referral Center, and 127 child care providers received scholarships to pursue early childhood coursework at Montgomery College.
  - 10,565 pieces of early childhood public engagement materials were distributed through integrated outreach efforts.
  - Onsite Early Childhood Mental Health Consultation Services were provided to 47 child care programs serving over 3,000 children.
  - Early Childhood Services budget: $6.5 million includes $3.2 million in contracts and 21 work years.

Performance

Percentage of Head Start, licensed child care centers and family-based child care students who demonstrate "full readiness"* upon entering kindergarten.



* The Maryland State Department of Education (MSDE) defines "full readiness" as "students consistently demonstrate skills, behaviors and abilities needed to meet kindergarten expectations successfully." Measurement takes place after entry into kindergarten. Hence, prior care is assessed in the context of a child's readiness to learn upon entry to kindergarten.

Discussion

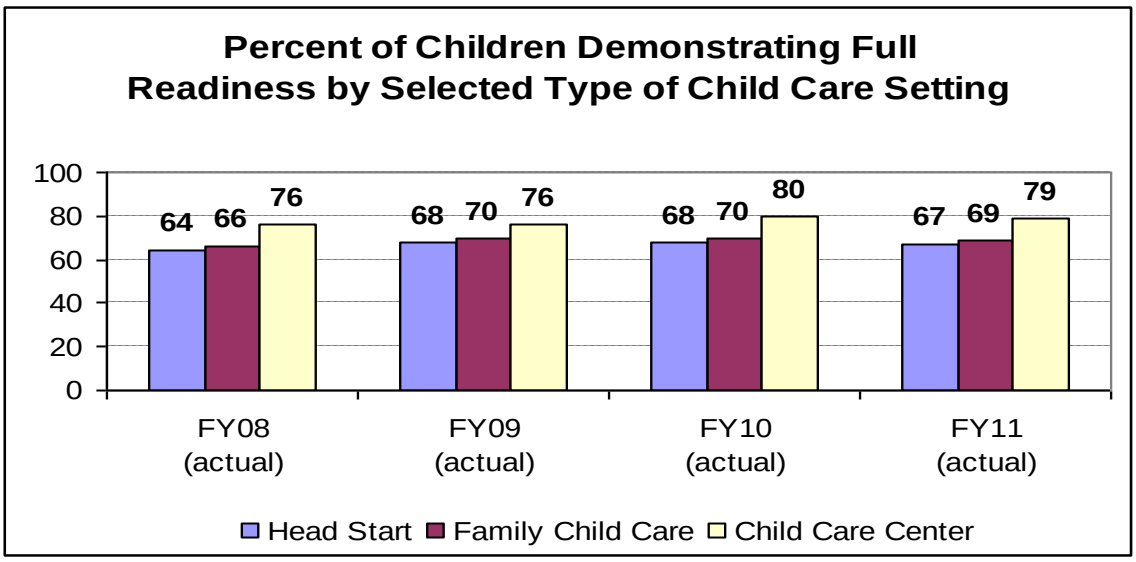
The percentage of county children achieving full kindergarten readiness has increased steadily in recent years. Although the County experienced a percentage point dip in children fully ready for kindergarten in FY11, the total number of those fully ready increased from the previous year.

Montgomery County has the highest number of English language learners in the state and an increasing number of children living in poverty. Both of these groups are considered "at risk" for lack of school readiness, and federal and state funding for both groups has decreased. Given these challenges that do not exist elsewhere in the state, Montgomery County is doing well.

Readiness scores are sensitive to broad demographic and economic trends. Montgomery County is expecting increasing numbers of kindergarteners, as well as an increasing percentage of children in groups which have traditionally lagged in school readiness. Our goal is to be able to maintain the level of kindergarten readiness, and as funds become available, target interventions to communities of need.

The overall average County composite percentage of children achieving full kindergarten readiness in FY11 was 73%. The results vary by type of prior child care setting as indicated in the chart on the next page. Those in MCPS pre-kindergarten, a setting

which is not included in this measure, in FY11 had 75%. A fifth category, Home/Informal Care, scored 67%, while a sixth (non-public nursery,) scored 83%.



Story Behind the Performance

Contributing Factors

- DHHS collaborates with State partners including the Office of the Governor, MSDE, Maryland Department of Health and Mental Hygiene, and County partners including MCPS, private non profit partners and other County agencies, to provide a continuum of comprehensive services to support successful transition of children to kindergarten and to show annual improvement in coordination and service delivery. Increased focus on collaboration among partners led to improvements in kindergarten readiness over the seven years (FY04-FY10).
- Effective MCPS Head Start curriculum, teacher and instructional assistant training, and program guidance and training of the family service workers and social workers that work with each Head Start family all contribute to better kindergarten readiness for children enrolled in the Head Start program.

Restricting Factors

- After years of an increasing percentage of entering Kindergarteners assessed as "fully ready," Montgomery County experienced a dip of two percentage points of children fully ready for kindergarten in FY11 (although the number of kindergarteners fully ready increased). This one year decrease in the percentage of children fully ready for kindergarten does not indicate a statistical downward trend, but must be monitored closely as the number of children in groups that have had lower percentages/rates of full readiness, such as English language learners and children living in poverty, continues to increase in Montgomery County. Funding for early childhood programs targeting these children has decreased at federal, state and local levels at the

same time the number of children at risk for lack of school readiness has increased.

- Fewer early childhood services were documented in FY11 as compared to FY10. With the economic downturn, the majority of programs, public and private, faced reduced budgets, while waiting lists and the eligible population grew. As American Recovery and Reinvestment Act funding runs out in FY11, additional reductions are expected.
- As of September 2011, a total of 1172 children were on the waiting list for child care subsidies. Children who do not have access to regulated child care programs may be cared for at home or in unlicensed settings, which may put them at risk for reduced school readiness.
- Children enrolled in Head Start who come from families with incomes below the federal poverty level face several disadvantages compared to their counterparts in privately-operated child care programs. According to the Montgomery County Community Action Agency, in FY11:

    - 48.6% came from single parent families
    - 55% came from homes where the primary language is not English
    - In 32.5% of Head Start families, the parents' highest level of education was less than high school; another 34.6% had only high school or General Equivalency Diplomas.

- A significant percentage of all immigrants coming into the State of Maryland settle in Montgomery County, creating challenges to providing culturally appropriate early childhood services.
- Lack of funding for public engagement educational outreach limits access to appropriate services and constrains progress in kindergarten readiness.

What We Propose to Improve Performance

- Under the auspices of the Early Care and Education Congress, an Action Agenda was adopted with strategies listed under three main goals: 1) Everyone will understand the need to support school readiness and their role in preparing children for school. 2) All young children will have access to high quality and culturally competent early care and education programs and health services that meet the needs of families, especially low-income families, families with children with disabilities and English language learners. 3) All professionals who work with young children will be appropriately educated in promoting and understanding a comprehensive approach for the development of the whole child, including physical, social-emotional and cognitive well-being as a basis for school readiness.
- Continue to work with the federal and state government to build coalitions and apply for any new funding that becomes available.
- In keeping with the State Early Childhood Advisory Council priorities for low income children, children with special needs, and children from families where English is a second language, seek data on Montgomery County's children in those categories and advocate for additional resources.
- Promote at every opportunity the message developed by the Early Care and Education Congress and featured on the one pager now used as an advocacy

piece statewide: During hard times, it is critical that we champion a family-focused early childhood service delivery system and that we maintain funding for the whole system of services that supports these important gains. A loss in any one program jeopardizes the overall design of the system.

10. Employment Services

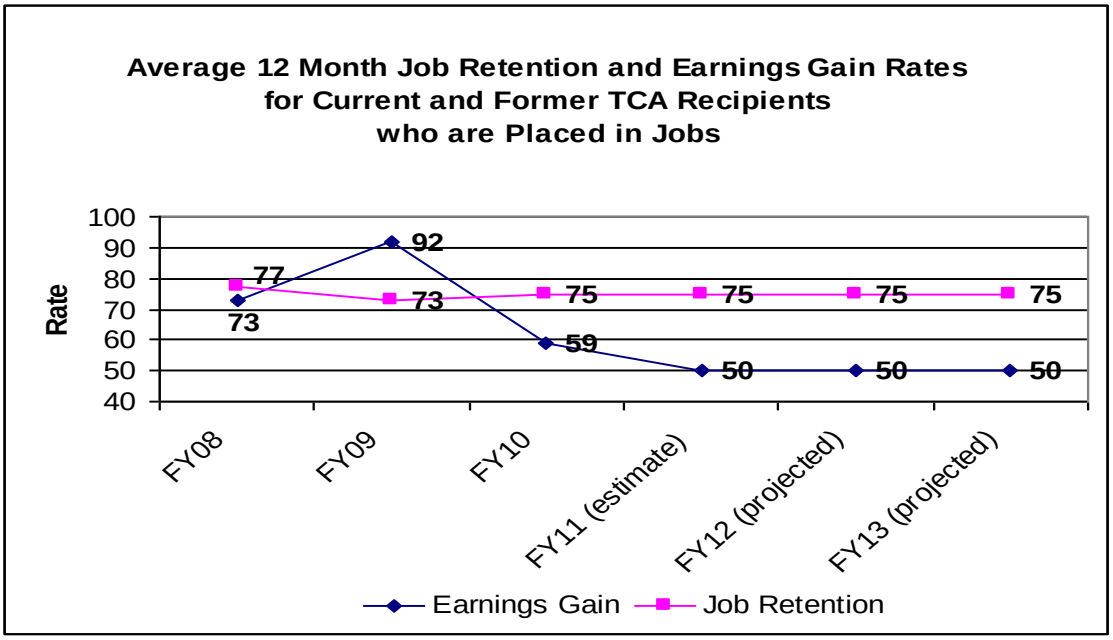
Basic Facts

- DHHS assists County residents who meet eligibility criteria in obtaining Temporary Cash Assistance (TCA), the federal cash benefit program.
- DHHS provides TCA recipients with assistance in accessing child care, transportation, housing, case management, child support, substance abuse and behavioral health treatment and other medical care services
- DHHS provides TCA recipients employment counseling, training and job placement services. Employment services to DHHS TCA recipients are provided through a contract with a private entity.
- In FY11, 610 TCA recipients were placed in jobs; 340 of those jobs were full time.
- Federal law requires that TCA recipients not exempted from the work program participate in employment activities leading to economic self-sufficiency in order to qualify for and retain TCA. If eligible, they can receive Medicaid and food supplements (formerly known as food stamps) and qualify for child care subsidies, transportation reimbursement and work incentives while participating in employment activities.

Performance*

Average 12 month Job Retention Rate for current and former TCA recipients who are placed in jobs

Average 12 month Earnings Gain Rate for current and former TCA recipients who are placed in jobs



* The State of Maryland tracks outcomes through WORKS, a state-wide data management system. Relevant outcomes are increased economic independence for TCA recipients that receive job placements, including

job retention rate and earnings gain rate. The data is compiled by matching the TCA cases that closed during a fiscal year against the Unemployment Insurance wage data from Maryland and the surrounding jurisdictions.

Discussion

The Earnings Gain Rate goal is 40% and the Job Retention goal is 70%. Montgomery County has consistently surpassed these measures in spite of the economic downturn and the increased volume in requests for assistance; the County still has a strong job market and higher wages than other Maryland jurisdictions, and DHHS has sustained great partnerships with several local employers. We expect to maintain the momentum and keep an average of 50% earnings gain rate and 75% job retention rate in the current fiscal year and beyond.

While Montgomery County remains above the State's goals, DHHS is experiencing a dip in our earnings gain measures due to the lagging economy and the competition for low to medium paying jobs. After a series of years with improved earnings for low income workers, employers are not as able or willing to increase wages to the newly hired. This results in a projected lower earnings gain rate, but we still project to exceed the State goal of 40%.

The County, through the WORKS data management system, tracks hourly wage rate at job placement, and percentage of individuals that are offered health insurance benefits within one year of case closure. In FY 11, Montgomery County was again highest in the State for average wage rate for TCA recipients at job placement ($11.51, up from $10.88 last year). The average hourly rate in Maryland in FY11 was $9.80. Three hundred fourteen of the 610 job placements offered health insurance within one year of employment, making the health insurance rate 51% (down from 53% last year but still exceeding our goal of 40%).

Story behind the performance

Contributing Factors

- DHHS contracts out the Employment Services program to vendors that are subject matter experts in employment support services.
- A team of DHHS staff with knowledge of Income Support programs, Welfare to Work policies and contract management oversees the daily operation of the Welfare to Work program.
- There is a strong commitment to facilitate the vendor's operation through a team approach with DHHS and vendor staff that emphasizes goal orientation, seamless processes, excellent customer service, transparency and accountability.
- Intensive case management and follow-up services provided to TCA applicants and recipients increase the likelihood that those eligible will be able to obtain and retain jobs that will enable them to become more economically independent.

- Strong partnerships with other public agencies (such as those related to economic development) and with private sector partners (such as job placement resources for internships and permanent employment), support program goals.

Restricting Factors

- Funding for intensive long-term tracking of client outcomes was cut in the past so that only minimal follow-up of TCA clients' employment status and job earnings now occurs.
- The significant increase in recent years in the number of TCA applicants and the TCA caseload is correlated with increased unemployment and the decline in the economy.
- The increase in TCA recipients and caseloads creates significant barriers to serving the most vulnerable customers and those with the most complex cases (i.e., customers with potential or undiagnosed mental health issues).
- The higher caseload has not been accompanied by an increase in staff; the increased demand for services has not resulted in any additional funding to support technical skills training.
- Less skilled workers are having a harder time finding permanent employment and are likely to get temporary jobs or contract jobs that end after a few weeks or months.
- The high cost of day care combined with the low earnings threshold to qualify for day care subsidies results in TCA participants' reluctance to find and keep jobs when they would lose the support systems they were receiving under TCA. Participants who become employed and are within Purchase of Care (POC) income guidelines can retain the subsidy; a lower paying job that allows a worker to keep their POC subsidy may be a better option.

What We Propose to Improve Performance

- Strengthen the comprehensive employment services program with continuing supports to TCA clients through service integration.

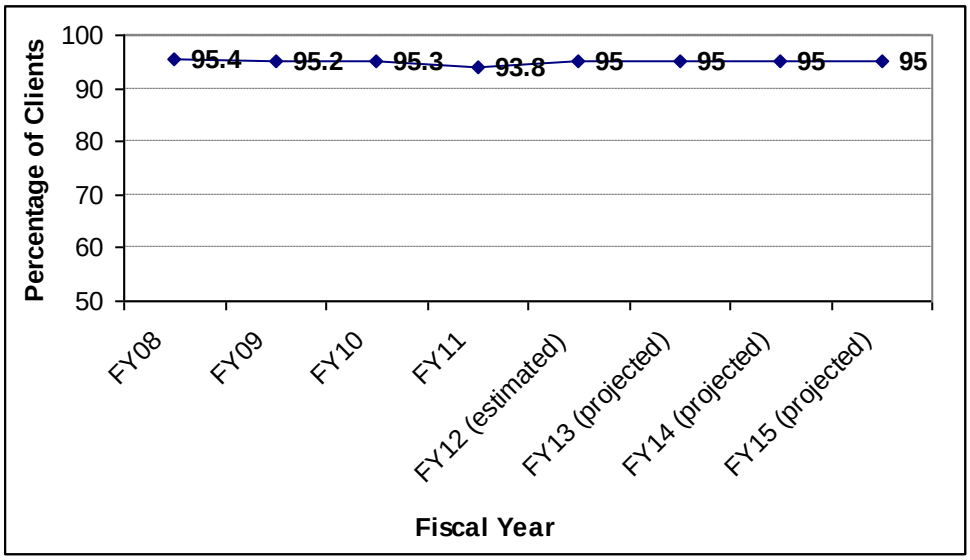
11. Maintaining Independence in the Community

Basic Facts

- DHHS provides assessment, continuing case management, and an array of services to elderly and disabled county residents, including: nursing assessment, personal care, housing subsidies, structured and supervised daytime activities, respite care, home modifications and assistive devices, and support groups for caregivers.
- One of the primary desires of senior and/or disabled populations is to remain independent in the community (i.e., 80% of elders express desire to remain living in their current homes for as long as possible).
- In FY2011 DHHS' Aging and Disability staff provided assessment and continuing case management services to over 2,000 unduplicated individuals.
- Services were provided by 50 work years of Masters level staff (40 Full-Time Equivalent (FTE) social work staff + 10 FTE Community Health Nurse staff)
- The DHHS Older Adult Waiver program allows for a more in-depth array of services to prevent premature institutionalization.

Performance

Percentage of seniors and adults with disabilities who avoid institutional placement while receiving case management services



Discussion

DHHS provided on-going case management services to a greater number of individuals in FY11 (over 1300) than in prior years (around 1100), and had a correspondingly greater number of individuals whose cases were closed due to institutional placement. The FY11 result is lower than past years due primarily to a higher than usual number of nursing home admissions. While one of the goals of service is to assist individuals remain

independent in the community, in some situations quality of life can only be attained through the provision of 24/7 nursing service available in a nursing facility.

At this time, DHHS is unsure based on one year of data, if FY11 represents the start of a trend. As the population served by DHHS becomes increasingly frail and vulnerable, and community and public resources are limited in nature, it is anticipated that the ability of DHHS to meet community needs will decline over time, though this may not be reflected in this particular outcome measure.

Historically good success in facilitating community placements is likely to continue. However, waiting lists (i.e., those whom we do not have the capacity to serve) will likely grow as well absent any staffing increases, due to dramatic increases in the senior population. DHHS will continue to adhere to standards that ensure quality service.

Story Behind the Performance

Contributing Factors

- Highly trained and knowledgeable staff provides services.
- Social support systems and services (critical factors in determining whether or not an individual will need nursing home placement or other institutional care) are available and accessible.
- An array of services are provided, including case management, nursing assessment, personal care, senior care, adult foster care, adult day care, respite care, group home subsidies, support groups for caregivers, home modifications and assistive devices.

Restricting Factors

- Budget constraints have progressively restricted service delivery to individuals at higher levels of functional impairment and risk for institutionalization. While the outcomes for people served have remained consistent, the capacity of HHS to provide services to all vulnerable individuals in need has declined due to staffing and funding limitations.
- The size of elderly and disabled populations is increasing, particularly among the oldest-old (age 85+) and those with cognitive impairment.
- The disabled elder population often has multiple and complex health problems (physical and cognitive).
- The waiting list for Older Adult Waiver (federal program administered through the State) is currently 1,709 and is anticipated to grow.
- Demographic projections indicate that as the number of disabled elders continues to increase, the number of informal supports (family or friends) available will decrease. This reduction is due to declining birth rates and greater percentages of adults in the work force.

What We Propose to Improve Performance

- Identify system factors that lead to higher vs. lower quality services through Quality Service Reviews.

- Increase coordination and teamwork between case management staff and staff with the Better Living at Home program (which provides environmental assessment by occupational therapist, with provision of assistive devices and home modifications as needed). In FY2010 the Better Living at Home program was awarded a national NCOA Innovations in Aging award, as well as a NACo award.
- Customer Directed Care, available through the In-Home Aide Service program, is an Evidence-based Practice that allows customers to design their own care provision plan, and hire family or friends to provide assistance. This innovation has produced better outcomes at lower costs than traditional service delivery.

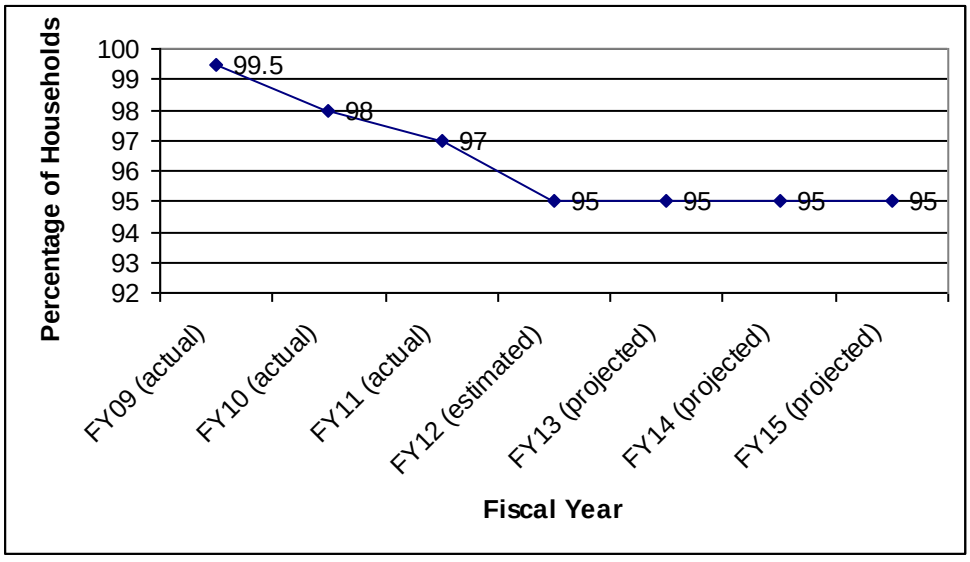
12. Housing Services

Basic Facts

- DHHS Housing Services work to:
  - Maintain housing stability for vulnerable households.
  - Prevent homelessness and the loss of permanent housing.
  - Promote expansion of affordable housing units for special needs populations.
  - Link housing with essential supportive services for special needs populations.
- In FY09, the Housing First Initiative began its first year of implementation with a focus on (1) reducing the length of stay in homelessness and providing stable housing for those exiting from homeless programs and (2) preventing homelessness by increasing emergency assistance resources and housing supports to stabilize housing for at risk households.
- In FY11, 6,111 crisis intervention grants were issued to assist households with preventing evictions, utility cutoffs and other emergency issues. A total of $1 million in Recordation Taxes were targeted to help prevent evictions, and funded 796 of these grants. County Funds of $1.8 million and State funds of $1.1 million funded 5,315 grants. In addition, federal American Reinvestment and Recovery Act funding in the amount of $491,000 supported 255 eviction prevention grants.
- In FY11, the Home Energy Assistance Program issued grants to help with electricity and heating costs to 9,483 households at or below 150% of the Federal Poverty Level.
- Numbers of people in permanent supportive housing have risen steadily over the past three years: 505 single adults based on the 2011 annual Point in Time Count and 278 families. This represents a 50% increase from 2009.

Performance

Percentage of households remaining housed at least 12 months after placement in permanent supportive housing.



Discussion

The combination of a deep housing subsidy and service coordination continues to be successful in helping formerly homeless individuals and families maintain housing. Retention rate continues to exceed national studies. This measure supports the Department's goal of reducing length of stay in homelessness through increased permanent housing capacity. The projected decline is due to increasing need and declining resources. The result for FY10 was calculated by dividing the 278 households that stayed at least 12 months in permanent supportive housing by the 287 households that were placed.

Three households in the Housing Initiative Program received Housing Choice Vouchers (HCV) in FY11 within the first 12 months of the program and, per program regulation, were closed. Had these households not received an HCV voucher, they would have remained in the permanent supportive housing program. If these closures are excluded from the denominator, the percentage of households remaining housed rises to 98.

Story Behind the Performance

Contributing Factors

- Specialized case management, mental health and substance abuse counseling and referrals to a range of services, such as mediation, training and employment help, supports the maintenance of housing stability for vulnerable households. DHHS also supports over 20 programs in Housing Stabilization Services, Transitional Housing, and Shelter Services, including 35 contracts that offer shelter, transitional housing and other programs benefiting poor and homeless people.
- DHHS provided assistance to an average of 1,397 low-income families and disabled and elderly households, whose incomes were below 50% of Average Median Income, to pay rent through the County's Rental Assistance Program (RAP) in FY11.
- DHHS provided assistance to a monthly average of 203 individuals who reside in a group home and have a mental illness, through the County's Handicapped Rental Assistance Program (HRAP) in FY11.

Restricting Factors

- Increasing unemployment and rising long-term unemployment has resulted in an increase in the number of families and individuals that are losing their housing and becoming homeless.
- The economic downturn has greatly increased the demand for eviction prevention services over the past several years.
- The Fair Market Rent ($1,513) for a two bedroom apartment in Montgomery County is high. A household must earn $60,520 annually ($29.10 per hour) to afford this level of rent and utilities without paying more than 30% of income on housing.
- High utility costs are placing an increasing financial burden on low-income families.

- Additional support services and intensive case management beyond rental subsidies are required to ensure special needs populations maintain their housing.
- Immigration status, poor credit history and criminal records impact rapid exit from homelessness.

What We Propose to Improve Performance

- Collaborate with DHHS partners to continue to implement the "Housing First" model to expedite the movement of homeless families and single adults into permanent housing.
- Provide case management services to support vulnerable households that seek financial assistance more than twice in a calendar year.
- Collaborate with HOC and DHCA to explore opportunities to increase the supply of affordable housing units.
- Update HUD Continuum of Care ten-year plan and align with Federal plan to end homelessness.
- Implement the Housing First Initiative's four primary goals:
    - Provide assistance to at-risk households to prevent homelessness;
    - Move homeless families through the intake/assessment phase of the system as quickly as possible;
    - Place households into suitable housing as quickly as possible;
    - Deliver the necessary services required to assure that households are able to stabilize their housing situation and prevent a reoccurrence of homelessness.

Appendix A
Budget Details for Proposed Strategies

All costs for strategies listed under "What We Propose to Improve Performance" for each measure will be absorbed by the Department's operating budget.

Appendix B
Implementation Timeline for Proposed Strategies

The timeline for strategies listed under “What We Propose to Improve Performance” for each measure is “ongoing”.

Appendix C
Headline Measure Under Construction and Steps for Developing Needed Data

EQUITY MEASURE

Contribution to Montgomery County Results

GREATER RESPONSIVENESS AND ACCOUNTABILITY

Background

Towards a systematic approach to promoting equity and social justice with customers, staff and community and to reducing disparities and disproportionalities in our vulnerable populations, the Department is developing a department-wide Equity and Social Justice Strategic Plan and logic model to:

- Assess, strategize, and implement a plan that ensures fair policies, decisions and actions by the Montgomery County Department of Health and Human Services (DHHS) when impacting the lives of people;
- Create a culture of inclusion that promotes fairness and opportunity in the use of resources, decision-making and all departmental interactions;
- Adapt and tailor approaches to achieve the best possible outcomes for the communities and customers DHHS serves; and
- Recognize and honor differences and the diversity of our community.

Performance

To be determined.

Steps for development of Equity measure

The following is an indication of how the work of identifying measures has proceeded:

1. Brought in a consultant to guide the work with grant funding
2. Formed a dedicated workgroup among staff representing all service areas
3. Established an overarching Mission/Purpose/Vision
4. Conducted 23 key informant interviews among internal and external partners
5. Held two community conversations with community members
6. Conducted a organizational self-assessment to determine the structures in place to support the equity work
7. Engaged in peer-to-peer learning with King County, WA which has successfully incorporated equity into the fabric of its work

8. Worked closely with the Community Health Improvement Process (CHIP) to align efforts to include internal/external focus.
9. Aligned efforts with the work to achieve full service integration

During FY12, we will:

1. Re-evaluate the role, function and authority of the Equity work group
2. Create an action agenda to translate the value of equity into policy and practice:
    a. Define what success will look like
    b. Establish a logic model to guide creation of action steps
    c. Determine what steps can be taken to adjust existing infrastructure in the immediate term to advance the vision of promoting Equity and Social Justice
    d. Identify what data are needed to move equity forward
3. Be more intentional and strategic regarding communication about equity work and values with DHHS staff
4. Engage Senior Leadership and DHHS managerial systems:
    a. Show the benefits of reducing disparities/promoting equitable approaches to promoting positive outcomes and fulfilling DHHS' mission.
    b. Provide training opportunities and material resource assistance.
5. Continue to work closely with CHIP to align efforts to include internal/external focus.

HOUSING SERVICES MEASURE

Contribution to Montgomery County Results

AFFORDABLE HOUSING IN AN INCLUSIVE COMMUNITY

Background

Special Needs Housing provides a range of services to resolve housing emergencies and prevent homelessness. As part of the Service Area's continuous quality improvement activities, it was determined that a more meaningful measure needed to be identified. The current measure, the number of households who receive financial assistance and request additional assistance within 12 months, did not meet our standards for data reliability and validity. As a result, consensus was reached that the existing measure needed to be revised.

Performance

A measure of the effectiveness of the homelessness prevention initiative is to be determined.

Steps for development of measure and needed data

Steps for developing this new measure include:

1. Obtain consensus from stakeholders regarding outcome measure
2. Clearly define measure
3. Identify data sources and data collection methodology
4. Pilot data collection and refine measure, as needed
5. Determine if FY12 can be a baseline year
6. Finalize and implement measure

DHHS Performance Plan

ADDENDUM
Responsive and Sustainable Leadership

Collaborations and Partnerships:

DHHS actively participates in collaborations and partnerships with other departments to improve results beyond the scope of its own performance measures.

Accomplishments:

Public Partnerships

Collaborating with the Universities at Shady Grove (USG) and Catholic University to develop opportunities for multi-disciplinary curriculum and internships for students, training for DHHS staff, grant acquisition and program evaluation.

Partnered with Finan and Springfield State Hospitals and State correctional facilities to coordinate and facilitate the return of more that 25 patients and inmates with complex behavioral health and human service needs.

Collaborating with the Mental Health Association of Montgomery County and the Commission on Veterans and Affairs to promote better access to mental health and human services for veterans and active duty military personnel and their families. This includes National Guard personnel and reservists.

Continued to serve veterans through the Veterans Collaborative coordinated efforts between Montgomery County, the State of Maryland, and the Federal Government.

Working with Maryland state departments to align the County's Healthy Montgomery Community Health Improvement Process with the State's Health Improvement Process. Participate in the State's Health Care Reform workgroup for health officers and the Health Benefit Advisory Committee.

Continue to work with Montgomery County Public Schools (MCPS) on programs and services to benefit school children and their families, including Linkages to Learning (LTL), Kennedy Cluster, Positive Youth Development (PYD) and school health.

Collaborate with MCPS and County departments of Recreation and Police on PYD for youth involved in or at risk of becoming involved in gangs.

Collaborate with County public safety departments to address issues of seniors, hoarding, domestic violence and behavioral health crises.

Work closely with County departments of General Services, Finance, Budget, Human Resources and Technology Services on DHHS operational programmatic activities.

Maintain strong State partnerships with departments of Health and Mental Hygiene, Human Resources, Education and Disabilities.

Continue work at federal level to support improvements in health and human services practice and systems. Recognized leaders in the area of health and human services integration.

Partnered with Housing Unlimited, Inc. (HUI), Springfield Hospital Center, and Maryland's Mental Hygiene Administration (MHA) and Department of Housing and Community Development (DHCD) to develop a plan for expansion of supported housing through HUI, resulting in the award of HUI funds to purchase 20 additional supported housing beds in FY12 and FY13. Priority will go to 18-20 supported housing vacancies for individuals referred from Residential Rehabilitation Programs, thus creating vacancies for individuals who are ready to be discharged from Springfield Hospital Center to supervised housing in Montgomery County's Residential Rehabilitation Programs.

Implemented a Recovery Discovery and Resiliency sub-committee in the Core Service Agency Wellness and Recovery Workgroup to initiate and implement Wellness and Recovery models for children and adolescents. Partnering with the MHA Transformation Office and the System of Care Training Institute, the sub-committee is focusing on implementing WRAP for Kids and the Transition to Independence Process model for adolescents. The goal is to train community providers that will implement these models in practice.

Provided 571 crisis evaluations at the Crisis Center during the school year to students referred by MCPS. Ninety-five percent of these evaluations resulted in the child or adolescent returning to school with an appropriate level of community services and support.

The Victims Assistance and Sexual Assault Program's sexual assault outreach volunteers partnered with Montgomery County Police Department and the SAFE nurses at Shady Grove Hospital to provide 24/7/365 days per year outreach to sexual assault victims and their loved ones.

Continued as a critical partner in the work of the Family Justice Center with the Abused Persons Program (APP). DHHS is a principal service provider in partnership with the Offices of the Sheriff and the State's Attorney. APP provides victim counseling, referrals for emergency shelter, and advocacy at the FJC.

The APP continues to oversee Implementation, including training, of the Lethality Assessment Protocol in use by the MCPD, the Office of the Sheriff, and DHHS.

Trauma Services partnered with the Governor's Office of Crime Control and Prevention to organize a crime victims Town Hall Summit Meeting in the County.

Continued operation of the Adult Drug Court Program near full capacity targeting non-violent offenders who receive intensive outpatient substance use and mental health treatment; 118 individuals were served in FY11.

Provided, through the Criminal Justice Behavioral Health Programs and the Access to Behavioral Health Services Program, 75 court ordered evaluations and implemented treatment placements in collaboration with the Justice Services Division of the Alcohol and Drug Administration, the Montgomery County Judiciary and local attorneys, the Department of Correction and Rehabilitation and Maryland Department of Corrections' Division of Parole and Probation.

Co-located County Attorney staff with Child Welfare staff

Continued, in third year of Kennedy Cluster Project, to provide multi-agency coordinated wraparound services to families of students who are in academic trouble.

The African American Health Program (AAHP) continued to partner with two projects to improve infant mortality and its antecedents, in collaboration with Prince Georges County.
Signed a Cooperative Agreement among participating County agencies to ensure a coordinated and effective response to prevention, investigation and remediation of serious hoarding behavior. Adult Protective Services staff participated in a hoarding presentation for the Maryland Chapter of the National Association of Social Workers Regional Conference.
Launched a Falls Prevention Campaign through the Senior Subcabinet in partnership with the Recreation Department, hospitals and others.
Collaborated with the State Department on Aging to launch a Maryland Access Point (MAP) for seniors, persons with disabilities and caregivers. MAP works to provide streamlined access to information and services for long-term supports and services.
The Commission on Veterans Affairs, in collaboration with the Office of the County Executive, hosted a Welcome Home Vietnam Veterans Second Annual Reunion that included a panel discussion by Vietnam Veterans and a presentation by Mr. Leggett regarding his 2009 trip back to Vietnam.
Worked with the Montgomery County Council on adoption of Executive Regulation 3-10 to implement the hiring preference for disabled veterans, people with disabilities and veterans. This regulation was strongly advocated by the Commission on People with Disabilities and later the Commission on Veterans Affairs
Participated with County departments of Police, Fire and Rescue, County Attorney and Office of States Attorney to promote World Elder Abuse Awareness Day to raise awareness on abuse, neglect, self-neglect and exploitation and supports available to seniors and vulnerable adults.
Contributed to effective emergency preparedness and response, under leadership from the Office of Emergency Management and Homeland Security, by opening two weather-related emergency shelters that served over 100 residents, and by providing four trainings, one countywide exercise, and two public education sessions.
The Elder Vulnerable Adult Abuse Task Force (EVAATF) received a 2011 National Association of Counties (NACo) Achievement Award.
Provided 7,040 doses of FluMist vaccine to children at 133 elementary schools through School Health Services, with support from Licensure and Regulatory Services, Communicable Disease and Epidemiology and MCPS.
Collaborated with the Department of Technology Services, MC311, MCPS and the USG to provide flu clinics to the residents of the county.
Developed a shared space agreement, using medical clinic space at the East County Regional Services Center, to provide services to uninsured low income adults in the Montgomery Cares Program. Partners include the Peoples Community Wellness Center and Mobile Medical Care.

Non-Profit and Private Partnerships

Collaborate with non-profit community partners to increase the capacity to provide health and human services to the community.

Continued work with PEPCO, Washington Gas and Capital One on homelessness and prevention activities.

Work closely with the Community Foundation of Montgomery County's Neighbors in Need program to ensure access to safety net services for individuals in need through referral to the DHHS Neighborhood Opportunity Network sites.

Partner with the Nonprofit Roundtable of Greater Washington through funding by the Community Foundation for the National Capital Region to provide training with non-profits serving Montgomery County to build competencies in administrative and financial processes.

Provided safety net and early intervention services to students in high poverty schools and their families, through the LTL program, with reduced staffing levels at many sites. Through this unique partnership among DHHS, MCPS and four nonprofit agencies, 1,037 students received mental health services and 1,006 families received family case management services to address socioeconomic needs.
Expanded Community Action Agency's volunteer participation in free tax assistance program (Voluntary Income Tax Assistance- VITA), increasing volunteer participation by 100% (to 68 individuals). This effort involved partnerships with municipalities and other business partners such as banks and the Maryland DHCD.
Partnered with Holy Cross Hospital, Casa De Maryland, Community Ministries of Rockville, the AAHP, and the Maryland Commission on Indian Affairs to coordinate the implementation of the Minority Communities Empowerment Project, a grant funded outreach initiative supported by the Maryland Occupational Therapy Association.
Partnered with Adventist Healthcare, Latino Health Initiative, AAHP, Asian American Health Initiative and the health departments of Frederick and Prince George's counties to host the 4th Annual Health Disparities Conference, which provided a platform for health professionals to advance knowledge of health concerns and health disparities.
Worked with community partners and MCPS to continue its teen pregnancy prevention efforts including providing 200 pregnant teens with prenatal and parenting case management.
Diversified participation and leadership through the Improved Pregnancy Outcome program to include representatives from area hospitals, health insurers, medical providers, women's health and minority health organizations, colleges and government agencies to improve systems of care for pregnant women in the County.
Conducted SSI/SSDO Outreach, Advocacy and Recovery (SOAR) training for 30 individuals and began sending SOAR applications forward to the Social Security Administration. The SOAR workgroup will add more partners in FY12.

Expectations:

Continue discussions between the Veterans Collaborative and the Veterans Administration on implementation of telemental health services in Montgomery County.

Workforce Diversity and MFD Procurement:

The Department of Health and Human Services actively participates in the recruitment of a diverse workforce and enforcement of MFD procurement requirements. Workforce diversity data for FY11 have not yet been provided by the Office of Human Resources. Accomplishments in the area of MFD procurement include the following:

In FY11, the dollar value of goods and services procured through MFD vendors was up by 11.4% from the previous year and by 27.6% from FY09.
The number of actions also increased from FY10 to FY11 (+12.5%)
Again, most DHHS awards to MFD vendors were in professional services, which had a 27.76% rate in FY11
The overall rate for DHHS, including non-professional services (25.22%) and goods (14.11%), was 26.25%
Professional services awards to Asian American vendors experienced the largest growth (+346% in dollars and +150% in actions)
The rate for goods was up by nearly 6 percent from FY10
Awards to Asian American vendors for goods were up 276% (although again this year, all actions were subcontracts)
Unlike the past two years, DHHS was successful in FY11 in making awards for non-professional services to female contractors and subcontractors. These represented 88% of all the dollars awarded in this category.

Innovations:

DHHS actively seeks to be innovative in its efforts to improve performance. The examples which follow are in addition to innovative practices noted in Collaborations and Partnerships above.

Accomplishments:

Continued work on equity initiative. Defined equity, conducted organizational assessment and community conversation to gather perceptions of equity generally and as it relates to DHHS, participated in peer learning with King County, Washington about their work around equity.
Identified, through the Healthy Montgomery Steering Committee, six health areas as the focus for improving the health of County residents: cardiovascular, diabetes, obesity, maternal and infant, cancer and behavioral health.
Advanced Technology Modernization work: Completed the proof of concepts for integrated eligibility and common client identification. Hired a project manager. Developed a task order for privacy and confidentiality review. Finishing a detailed assessment of interfacing with the State's case management system. Continue to work/lobby for foundation and other private contributions to support the project.
Participate in Health Care Reform workgroups for health officers and on the Health Benefit Advisory Committee. Aligning the County's Healthy Montgomery Community Health Improvement Process (CHIP) with the State's Health Improvement Process. Provide the State with monthly reports on progress and information for their website.
Continued to transform the homeless system through the Housing First Initiative by converting three family shelters into Assessment Shelters to rapidly re-house families; implemented a uniform assessment tool to better document the needs of households. Received 2011 National Association of County Achievement Award for Housing Initiative Program in recognition of best practices among counties across the nation.

Established and maintained a cumulative data repository of Public Mental Health System (PMHS) clients. This helped to ensure evaluation of utilization patterns of PMHS services by county's Medicaid clients in a timely and dynamic manner and provide support to quality control and monitoring of service provision by Mental Health Core Service Agency Team.

Adopted ArcGIS Mapping tool to illustrate characteristics of clients served in the community in the context of current economic, demographic and social trends as reflected by Census data and American Community Survey. The use of the mapping tool allows for informed planning of behavioral health system resources and enhanced preparedness for crisis/emergencies. Through mapping of Residential Rehabilitation Program facilities, PMHS clients locality, and DHHS high service use zip codes, CSA-BHPM took advantage of GIS data-identified trends to respond to needs of under-served communities/populations.

Expanded the scope of resource and service planning through introduction of predictive modeling techniques to identify determinants of co-morbidity among PMHS clients. Significant findings from analysis provided insightful guidance to future formulation of local policy addressing co-morbidity issue for PMHS clients.

Senior Mental Health conducted a pilot training for assisted living providers. The training focused on mental health and cognitive impairment. The goal was to increase provider's willingness to accept client with behavioral health issues; to provide success of placements; and to make providers aware of county resource to assist them in successful placement.

Involved county residents and graduate students from the University of Maryland as participants in the community review process to evaluate eight DHHS programs and recommend improvements when necessary.

Facilitated 1,404 visits between 200 children and their 133 families at the Visitation House, a child welfare program that provides a home-like atmosphere for supervised visitation. Visitation House is a project between various departments of Montgomery County government, (DHHS, DHCA, the County Attorney), the Courts, the legal community and community agencies.

Provided services to fathers and families and children involved in Child Welfare Services (CWS) through the Responsible Fathers and Winning Fathers programs with the overall goal of enhancing the relationship of fathers with their children. Winning Fathers' program primary goal is to improve the success of Fathers re-entering the greater community after being incarcerated. Responsible Fathers' primary goal is to enhance father's involvement with their children.

The Extended Option, launched in FY10, continued to enable Montgomery County's Infants and Toddlers Program (MCITP) to serve children beyond age 3. A major focus was expansion of community-based programming to offer all MCITP children greater opportunities to build essential social, emotional and early educational skills necessary to be prepared for kindergarten.

Community Action's VITA collaborated with MC311 to increase residents' access to a broad range of free tax help services (i.e., RSVP/AARP'S Tax Counseling for the Elderly-TCE, Community Tax Aid, and Military VITA).

The Asian American Health Initiative (AAHI) launched the Health Education in Ethnic Media Campaign, a series of culturally relevant health education articles published in local ethnic media, which many non-English speakers in the community rely on as a primary source for news.

AAHI conducted the first of a series of practical and professional technical assistance training workshops designed to empower and enhance the ability of community leaders to develop culturally and linguistically competent health programming. The workshop topic was MCDHHS 101. Thirty community leaders representing 13 different organizations attended the workshop.
AAHI launched a new e-publication "Voices Among the Silent: Stories of Struggle and Strength from Asian Americans in Montgomery County, Maryland". The book intends to educate and raise awareness about the wide range of challenges faced by the Asian American community related to health, healthcare access, immigration, and language proficiency, etc.
Partnered with the Maryland Department of Health and Mental Hygiene to begin use of a new blood test to screen for tuberculosis. This new test (Quantiferon Gold) is more sensitive and better able to provide true results (positive or negative) than the previously used skin test. Its use has resulted in a decreased number of people needing x-rays and treatment for latent TB infection.
Montgomery Cares Homeless Health program has begun an innovative collaboration with Licensure and Regulatory Services to assist homeless shelters and soup kitchens with ensuring food safety.
Fully implemented the online school health room data entry system "HERO" at all 200 schools, allowing for the capture of comprehensive data in a timely manner. There were 544,094 visits to the health rooms, with 87% of the students successfully returning to class.
Public Health Service's Advanced Practice Center launched rx4prep.org, an online resource to help local health departments and pharmacists work together on emergency preparedness.
Public Health and CWS participated in a pilot collaborative team project involving Community Health nurse case managers working with Child Welfare families. The project demonstrated that the Community Health nurses' expertise was most effectively utilized by the Child Welfare Assessment Unit during the initial assessment and investigative home visit.
Continued development and implementation of an integrated case practice model that uses collaborative team-based case management as the mechanism to establish case goals and identify the actions expected of service providers and/or clients to achieve them. The initial phase of implementation, including team meetings among all parties involved, focuses on transition-age young people (ages 16-24).

Expectations:

Successfully complete Homelessness Prevention and Rapid Re-housing Program to prevent homelessness, ARRA grant.
Move forward on schedule with the County's plan to expand School Based Health-Wellness Centers. A Linkages to Learning School Based Health Center opened at Rolling Terrace Elementary School in August 2010, joining four others.
Identify staff to participate in long term planning for integrated eligibility and common client index automation projects.

Continue implementation of the integrated case practice model including development of policy, process and procedures manual. Begin to expand use of model to broader client base in DHHS.
Complete implementation plan for technology modernization.
Deploy new enterprise data system functionality to support the Department's Service Integration initiatives, including automation of a currently manual process of appointment scheduling for clients.
Continue work to promote equity and social justice in service delivery to improve outcomes for individuals and families receiving services. This internal process will blend with the CHIP and result in the formation of a specific action agenda.
Continue development of Public Health Emergency Preparedness and Response team's prototype for online training to prepare DHHS employees for potential roles and responsibilities in staffing Montgomery County's Medication Centers during a bioterrorism incident or other public health emergency response.
Develop and implement a pilot to prevent childhood obesity through School Health Services $20,000 grant from the Mead Foundation. The goals are to increase student activity, support healthy food choices among students and develop partnerships with MCPS and other agencies to support the program. The funds will be used to develop curriculum, tools and resources for nurses and to track and report outcomes during FY12 and in future years
Initiated a "redesign" of the Outpatient Addiction Services – Intensive Outpatient Program to evolve and develop a program that is tailored to individuals with co-occurring mental health and addiction disorders; the effort will be completed and implemented in FY12.

Effective and Productive Use of the Workforce/Resources:

a) DHHS reduced overtime hours used by 34.8% from FY10 to FY11, and reduced by 43.6% the number of overtime hours in excess of the budgeted hours. DHHS actively works to effectively and productively use its workforce/resources, including, but not limited to, implementation of productivity improvements, reduction of ongoing costs, and efficient use of other resources. The examples which follow are in addition to Innovations and Collaborations and Partnerships noted above.

b) See below for additional accomplishments and expected results:

Accomplishments:

Expanded homeless prevention efforts, through Federal Homelessness Prevention and Rapid Re-housing grant, to help 70 households with incomes below 50% of AMI avoid homelessness by providing financial assistance and case management; provided temporary rent subsidies to rapidly re-house 53 homeless households.
Undertook a redesign process in Behavioral Health and Crisis Services that resulted in more effective use of staff, and established more direct access to service across its programs. Key elements include: an integrated jail Diversion and Reentry Service

(DRES); a redesigned Access Intake service and Safety net services; the integration of SASCA with Child and Adolescent Mental Health Services; and a redesigned Intensive Outpatient Services. The redesign led to the redeployment of staff and managers to close gaps in services and strengthen current program operations.

Increased access to eligible crime victims to the State's Criminal injuries Compensation Fund.

Used Geographic Information System mapping tool to map BHCS facilities, housing program bed capacity, hot spots/areas of clients to support planning and management of services, spatial analysis, and comparison and evaluation of trends in the quality and delivery of behavioral health services in Montgomery County.

Developed and administered a supervised housing survey for individuals living with mental illness to determine the number of Residential Rehabilitation Program (RRP) residents that believe they are ready to move to supported housing and to determine the existing barriers to moving residents to supported housing. The broader goal is to create vacancies in the RRP for individuals who are ready for discharge from Springfield Hospital Center.

Reduced the number of separate software applications used to support the Department's direct service operations from 130 to 34 current systems.

Completed Phase 1 Information Technology Assessment to understand current program processes, develop a vision for change and perform a technology review of the current enterprise application.

Implemented daily download of state CARES information regarding clients served in Montgomery County. This extensive data load provides critical information to the Department, is much easier to extract and more useful than other extraction methods.

Held 380 Family Involvement Meetings (FIM) related to 579 children. The facilitated meetings address child safety, wellbeing, permanency and placements needs of children involved in Child Welfare Services. Satisfaction surveys indicated continuing support for the meetings from biological family members, community partners, social workers, and supervisors. FIMs helped reduce the number of children in foster care by 7%,; speed reunification, increase placement with relatives by 28% and increase adoptions (through open adoption agreements) by 50%.

Served 1,085 youth through Positive Youth Development in various programs at the Northwood High School Wellness Center, Crossroads Youth Opportunity Center, Up County Opportunity Center and the Montgomery County After School Program; 813 of these youth (74%) participated in after school programs. Additionally, 184 high risk and gang-involved youth were served by the DHHS Street Outreach Network and 24 gang related conflicts were resolved through the work of this program's staff and its partners.

Responded and served families needing help to meet basic financial needs through Income Supports and Child Care Subsidy staff efforts. The number of applications for services increased 24% at the three regional income support offices and caseloads rose by 36% over two years.

Expanded the Parent Resource Centers, which moved to DHHS, to serve additional families. Enrollment increased to 329 families in FY11, compared to 279 in FY10, benefiting from close partnership with Montgomery County Infants and Toddlers Program (MCITP). ESOL numbers increased by 31%, and the number of children with disabilities increased by 88%.

Improved Medical Assistance (MA) collections in MCITP through a concerted joint effort by the regional site staff and the central offices of MCITP. In 2010, the rate of collection

for 512 MA-enrolled children resulted in an average collection rate of 86% of potential revenue. This revenue significantly contributes to the sustainability of various initiatives in the program

Implemented a new menu labeling law through Environmental Health (Licensing and Regulatory Services) while increasing the rate of completed mandated food service inspections by 6% over the previous year. Achieved the 80% target without hiring additional personnel or increasing overtime costs.

Established MC311 as point of contact for calls for information and referral for primary care services and patient navigator support for Minority Health programs.

Provided 513 referrals to County agencies from the African American Health Program (AAHP)'s Start More Infants Living Equally Healthy Program.

Provided services and referrals to more than 7,000 residents through the AAHP, an increase of 2,000 residents (a 40% increase over FY10.

Promoted health and the prevention of diseases that impact Asian Americans including cancer, hepatitis B, diabetes, osteoporosis, as well as tobacco control. Initiated Health Education in the small Business Program. Provided 4,801 educational encounters, 1688 basic health screenings, and 342 referrals to different health services.

Provided hepatitis B education, screening, vaccination and treatment referrals in a culturally and linguistically competent manner to 114 community members. Successfully developed a model to eliminate hepatitis B disparity among the Vietnamese community.

Trained departmental leadership on emergency preparedness including continuity of operations planning and operational procedures for DHHS to sustain essential functions and eventually restore full functionality during a major emergency. Provided training on the DHHS "All Hazards Plan" and training for school health room aides on anthrax response planning efforts, involving distribution of life-saving medications to the public in the event of a future anthrax attack.

Provided education through the Latino Health Initiative Asthma program to 29 parents/caregivers who reported increasing by 94.3% their ability to manage their children's asthma and decreasing Emergency Department visits by 50%, hospitalizations by 50.8%, and school days missed by 20%.

Honored as a recipient of the *Migration Policy Institute 2011 E Pluribus Unum* Prizes for exceptional immigrant integration initiatives. The Suburban Maryland Welcome Back Center, as part of the National Welcome Back Initiative, was recognized for serving health professionals from all over the world currently residing in the area to prepare for and obtain licenses required to work in the health field. Eleven foreign-trained nurses obtained the Maryland Registered Nurse license and joined the health workforce in Maryland with a 292% increase in wages.

Provided 6,931 community members with health education services, and 535 referrals to health and human services in the County, through the "*Vias de la Salud*" Health Promoters Program, Latino Youth Wellness Program and Asthma Management Program.

Provided 106 hours of training to 26 Latino Health Promoters on participatory methodology, health promotion, and asthma supportive interventions techniques.

Expectations:

Reduce the length of stay of families in homelessness through implementation of the family assessment shelter model, focusing on rapid re-housing and case management.

Continue to reorganize the structure of the Continuum of Care in preparation for implementation of the McKinney-Vento Amendment, Homeless Emergency and Rapid Transition to Housing (HEARTH) Act.
Increase supply of permanent supportive housing for individuals.
Continuing implementation of Housing First Initiative by converting three family shelters into Assessment Shelters, thus maximizing the number of beds available to homeless families.
Complete preparation for Business Module of ERP system and train staff on new requirements and system.
Develop data warehouse initially fed from eight sources to facilitate reporting locally on client-based activities and provide key data elements to link with ERP data for more comprehensive reporting.
Determine eligibility for applicants within 30 days for Temporary Cash Assistance and Supplemental Nutrition Assistance program (Food Stamps) and within the appropriate timeframes for Medical Assistance for Families and Children and the Maryland Children's Health Program.
Strengthen the support available to parents for the development of their children by identifying additional resources for the Parent Resource Centers within DHHS.
Place 69 homeless individuals and families in permanent supportive housing to fill the remaining available permanent supportive housing subsidies.
Integrate behavioral health and primary care services in Outpatient Addictions Services, Access and Adult Behavioral Health.
Improve integration of behavioral health and primary care services to uninsured and ineligible County residents.

Succession Planning:

DHHS does not currently have a list of key positions/functions that require succession planning. DHHS actively plans for changes in its workforce, in order to maintain continuity of services, develop staff capabilities, maintain and/or transfer knowledge, and enhance performance.

DHHS currently is not able to calculate a percent of key positions/functions for which the department has developed and implemented long-term succession planning. In FY12, a list of key positions/functions that require succession planning will be created. Please see below for accomplishments and expectations in the area of succession planning.

Accomplishments:

Developed and began implementation of knowledge transfer process to capture and transfer tacit knowledge of key administrative positions
Conducted succession planning survey
Proposed workforce development program to enhance staff competencies and capabilities for leadership development.
Completed the integration of Trauma Services under one manager following the resignation of a Manager and the elimination of one M-III position due to budget cuts.

Realigned managers to address the losses of staff due to resignations and position cuts.
Actively recruited Supervisory Therapists and program managers to fill key vacancies throughout the second half of FY11.

Expectations:

Completing and fully implementing a comprehensive recruitment, outreach, retention and succession plan.
Continuing to administer staff exit questionnaires and conduct exit interviews
Develop a specific succession plan to replace the Manager of the Behavior Health and Crisis Services – Treatment Services programs
Seek opportunities to promote qualified line staff into management positions.

Internal Controls and Risk Management:

60% of the 15 Internal Audit Report on Contract Monitoring recommendations (released in May 2011) have already been fully implemented by DHHS. DHHS actively assesses its internal control strengths, weaknesses, and risks regarding compliance with laws and regulations, recording of financial transactions and stewardship over County assets. DHHS comprehensively reviews and implements Internal Audit recommendations in a systematic and timely manner, according to the established deadlines, and prepares and implements short-term and long-term action plans. DHHS reviews and assesses the applicability of Internal Audit report findings to all other departmental programs/activities and implements solutions where risks are found. All of the findings and recommendations in the May 2011 Internal Audit were specifically related to contract monitoring, which is a department-wide initiative.

DHHS also manages risk pertaining to improving workplace safety, decreasing work-related injuries, and reducing County exposure to litigation. See below for accomplishments and expected results:

Accomplishments:

Developed improvements to the County's non-competitive contract process to allow funding to cross fiscal years and to facilitate timely processing.
Received a three year accreditation from the Commission on Accreditation of Rehabilitation Facilities for the Outpatient Treatment – Opioid (Methadone) Treatment Program for Adults as mandated by the Substance Abuse and Mental Health Services Administration and the Maryland Alcohol and Drug Abuse Administration.
Developed Strategic Plan for Improving Contract Monitoring and invoice payments; conducted training for program monitors and vendors
Determined the number of accidents and incidents, as reviewed quarterly, were not significant.

Expectations:

Complete implementation of improved program and fiscal monitoring of the Department's contract portfolio which exceeds 500 contracts and $80,000,000.

Environmental Stewardship:

DHHS actively makes appropriate changes to workplace operations, workflow, employee behavior, equipment use, and public interactions to increase energy-efficiency, reduce its environmental footprint, and implement other environmentally responsible practices.

Expectations:

Meet paper and printing reduction targets issued by OMB
Meet energy efficiency guidelines determined by the Department of General Services

Mandatory Employee Training:

Montgomery County is committed to providing a workplace that promotes fairness, equity, and safety for all its employees. We have a responsibility to comply with federal state, and county laws. To ensure manager and employees are aware of the County's policies, we provide mandatory training for all employees. It is the responsibility of employees and their Managers to ensure all appropriate training is taken.

DHHS Employees are required to attend certain classes depending upon their job responsibilities in order to provide inclusive customer service, as well as to ensure the safety of our customers and our staff.

DHHS systematically monitors and actively enforces employees' mandatory and/or required trainings. Until such time as the ERP is able to provide reports on the percentages of employees who have fulfilled mandatory training requirements, DHHS supervisors will continue to track the attendance of their staff at mandatory County/State/Federal training required of them (e.g., Child Welfare workers are required to take Legal Requirements: What You Must Know When Working with Clients).

In FY11, there were 4,057 training attendances (both mandatory and non-mandatory) by DHHS employees (still employed at year's end) at classes conducted through the Office of Human Resources. Attendees completed those classes 97.2% of the time.

100% of all new FY11 employees took mandatory HIPAA, computer security awareness, and Introduction to Limited English Proficiency (LEP) training as part of the DHHS New Employee Orientation (conducted 17 times in FY11).
Over one-third (35%) of all new FY11 employees have taken the "LEP Implementation Plan" training on DHHS' policy and protocol for accessing language services to assist

customers who have LEP. This class is required in the first year of employment. All already-trained employees are encouraged to complete the training as a refresher, and many do so.

In FY11, the Office of Community Affairs conducted eight sessions of "LEP Implementation Plan" trainings for 112 employees and interns, one "Community Interpreter" training for certified bilingual staffs, and one "How to Work with an Interpreter" training for 31 employees.

DHHS invested in building internal training capacity by sending a staff person to be trained and licensed to conduct the Community Interpreter training for bilingual staff. From FY12 and beyond, DHHS expects this course to be conducted by internal staff instead of paying an outside consultant to provide the training. There is a need for DHHS to make this investment due to the large number of bilingual staff employed.

Preventing Workplace Harassment must be taken within the first three months of employment and thereafter as a refresher every three years. Of those employees hired in FY11, over one-third (36%) had taken the training by the end of the second quarter of FY12.

The period for completion of the six OHR-required training classes by newly-hired or promoted DHHS managers (including supervisors) varies according to the length of their probationary period. DHHS hired or promoted nine new managers in FY11. One-third (33%) have already completed or are within one class of fulfilling their requirement as of the end of January 2012.

Employees working in programs related to certain funding sources must take Time Study training to assist DHHS in accounting for staff time when claiming reimbursement. Results for FY11 reveal the following completion rates for FY11 employees who are still with DHHS and who were required to complete the training:

92% for Title XIX; and
81% for Title IV-E

For FY12 and going forward, DHHS will track specifically the numbers of Managers completing Mandatory training and ensure that employees complete DHHS LEP Implementation Plan training.